LAW
KF
3608
A4
U5
1976h

MEDICARE REIMBURSEMENT ISSUES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

AUGUST 3; SEPTEMBER 15 AND 16, 1976

AUGUST 3, 1976—Recommendations Relating to Revisions in the Medicare Hospital Reimbursement System

SEPTEMBER 15, 1976—Recommendations Relating to Revisions in the Medicare Physician Reimbursement System

SEPTEMBER 16, 1976—Medicare Policy Relating to Reimbursement of Physicians in Teaching Hospitals

Printed for the use of the Committee on Ways and Means

KF
3608
.A4
U5
1976h

MEDICARE REIMBURSEMENT ISSUES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

AUGUST 3; SEPTEMBER 15 AND 16, 1976

AUGUST 3, 1976—Recommendations Relating to Revisions in the Medicare Hospital Reimbursement System

SEPTEMBER 15, 1976—Recommendations Relating to Revisions in the Medicare Physician Reimbursement System

SEPTEMBER 16, 1976—Medicare Policy Relating to Reimbursement of Physicians in Teaching Hospitals

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
75-853 O WASHINGTON : 1976

COMMITTEE ON WAYS AND MEANS

AL ULLMAN, Oregon, *Chairman*

WILBUR D. MILLS, Arkansas
JAMES A. BURKE, Massachusetts
DAN ROSTENKOWSKI, Illinois
PHIL M. LANDRUM, Georgia
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
JAMES C. CORMAN, California
WILLIAM J. GREEN, Pennsylvania
SAM M. GIBBONS, Florida
JOE D. WAGGONNER, Jr., Louisiana
JOSEPH E. KARTH, Minnesota
OTIS G. PIKE, New York
RICHARD F. VANDER VEEN, Michigan
J. J. PICKLE, Texas
HENRY HELSTOSKI, New Jersey
CHARLES B. RANGEL, New York
WILLIAM R. COTTER, Connecticut
FORTNEY H. (PETE) STARK, California
JAMES R. JONES, Oklahoma
ANDY JACOBS, Jr., Indiana
ABNER J. MIKVA, Illinois
MARTHA KEYS, Kansas
JOSEPH L. FISHER, Virginia
HAROLD FORD, Tennessee

HERMAN T. SCHNEEBELI, Pennsylvania
BARBER B. CONABLE, Jr., New York
JOHN J. DUNCAN, Tennessee
DONALD D. CLANCY, Ohio
BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
WILLIAM A. STEIGER, Wisconsin
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
JAMES G. MARTIN, North Carolina
L. A. (SKIP) BAFALIS, Florida
WILLIAM M. KETCHUM, California

John M. Martin, Jr., *Chief Counsel*
J. P. Baker, *Assistant Chief Counsel*
John K. Meagher, *Minority Counsel*

Subcommittee on Health

DAN ROSTENKOWSKI, Illinois, *Chairman*

JAMES C. CORMAN, California
OTIS G. PIKE, New York
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
JOE D. WAGGONNER, Jr., Louisiana
WILLIAM R. COTTER, Connecticut
MARTHA KEYS, Kansas

JOHN J. DUNCAN, Tennessee
PHILIP M. CRANE, Illinois
JAMES G. MARTIN, North Carolina
DONALD D. CLANCY, Ohio

CONTENTS

Tuesday, August 3, 1976 (Pages 1–290)

RECOMMENDATIONS RELATING TO REVISIONS IN THE MEDICARE HOSPITAL REIMBURSEMENT SYSTEM

Page

Press release of Thursday, June 24, 1976, announcing hearing on recommendations relating to revisions in the medicare hospital reimbursement system ---- 2

Committee print "Cost-Based Reimbursement of Hospitals Under Medicare" ---- 4

WITNESSES

Aetna Life & Casualty, Daniel W. Pettengill ---- 38

Ainsworth, Thomas H., Jr., M.D., Illinois Masonic Medical Center ---- 188

American Association of Retired Persons, Ralph Borsodi, Laurence F. Lane, and James M. Hacking ---- 89

American Hospital Association, John Alexander McMahon and Leo J. Gehrig ---- 14

Association of American Medical Colleges, Charles B. Womer and Richard Knapp ---- 79

Bradley, John A., Federation of American Hospitals ---- 49

Blue Cross Association, Neil Hollander ---- 61

Borsodi, Ralph, American Association of Retired Persons and National Retired Teachers Association ---- 89

Bromberg, Michael D., Federation of American Hospitals ---- 49

Edwards, Arch B., McKinsey & Co., Washington, D.C ---- 217

Federation of American Hospitals, Michael D. Bromberg and John A. Bradley ---- 49

Finley, Joanne F., M.D., New Jersey Department of Health ---- 130

Gehrig, Leo J., American Hospital Association ---- 14

Gent, Donald I., Welborn Baptist Hospital ---- 200

Hacking, James M., American Association of Retired Persons and the National Retired Teachers Association ---- 89

Hamilton County, Fla., Memorial Hospital, Robert B. Marvin ---- 224

Hawkins, Joe D., National Association of Insurance Commissioners ---- 105

Health Insurance Association of America, Daniel W. Pettengill and William C. White ---- 38

Hofrichter, Frederick L., Interreligious Coalition on Health Care ---- 211

Hollander, Neil, Blue Cross Association ---- 61

Illinois Masonic Medical Center, Thomas H. Ainsworth, Jr., M.D., and James H. Obriecht, CPA ---- 188

Interreligious Coalition on Health Care, Frederick L. Hofrichter ---- 211

Knapp, Richard, Association of American Medical Colleges ---- 79

Lane, Laurence F., American Association of Retired Persons and the National Retired Teachers Association ---- 89

Lipitz, Roger C., National Council of Health Care Services ---- 159

Marvin, Robert B., Hamilton County, Fla., Memorial Hospital ---- 224

Maryland Health Services Cost Review Commission, Mancur Olson ---- 114

McMahon, John Alexander, American Hospital Association ---- 14

National Association of Insurance Commissioners, Joe D. Hawkins and Dick L. Rottman ---- 105

National Council of Health Care Services, Roger C. Lipitz ---- 159

Page
National Retired Teachers Association, Ralph Borsodi, Laurence F. Lane, and James M. Hacking ... 89
New Jersey Department of Health, Joanne F. Finley, M.D. and John Reiss, Ph. D ... 130
Obriecht, James H. CPA, Illinois Masonic Medical Center ... 188
Olson, Mancur, Maryland Health Services Cost Review Commission ... 114
Pettengill, Daniel W., Aetna Life & Casualty and the Health Insurance Association of America ... 38
Prudential Insurance Co., William C. White ... 38
Raino, Dominic B., United Mine Workers of America ... 145
Reiss, John, Ph. D., New Jersey Department of Health ... 130
Rottman Dick L., National Association of Insurance Commissioners ... 105
United Mine Workers of America, Dominic B. Raino ... 145
Welborn Baptist Hospital, Donald I. Gent ... 200
White, William C., Prudential Insurance Co ... 38
Womer, Charles B., Association of American Medical Colleges ... 79
Worthington, Prof. Paul, Slippery Rock State College, Pa ... 227

MATERIAL SUBMITTED FOR THE RECORD

American Federation of Labor and Congress of Industrial Organizations, statement ... 233
American Medical Association, James H. Sammons, M.D., letter ... 235
American Osteopathic Hospital Association, Michael F. Doody, statement ... 237
Broyhill, Hon. James T., a Representative in Congress from the State of North Carolina, letter ... 245
Burns, Chris, C.P.A., Emeryville, Calif., letter with enclosure ... 247
Catholic Hospital Association, statement ... 249
Community Service Society, Charles B. Dorf, letter ... 254
Connecticut, State of, Commission on Hospitals and Health Care, F. Bernard Forand, exchange of correspondence with Congressman Vanik ... 255
Cruikshank, Nelson H., National Council of Senior Citizens, Inc., statement
DeWald, Alwen, Physical Therapy Society of Pennsylvania, letter ... 286
Doane, Mildred, Ph. T., Rhode Island Physical Therapy Society, Inc., letter ... 286
Doody, Michael F., American Osteopathic Hospital Association, statement ... 237
Dorf, Charles B., Community Service Society, letter ... 254
Dove, Roger, Insurance Association of Connecticut, statement ... 260
Ellis, R. Archie, National Council of State Public Welfare Administrators, American Public Welfare Association, statement ... 275
Fahey, Sandra J., Health Planning and Development Council for Broward County (Fla.), statement ... 258
Forand, F. Bernard, Commission on Hospitals and Health Care, State of Connecticut, exchange of correspondence with Congressman Vanik ... 255
Golden State Physical Therapy Association of California, Inc., Merlin L. Kemp, Ph. T., letter ... 286
Griffith, John R., Program and Bureau of Hospital Administration, University of Michigan, School of Public Health, statement ... 277
Health, Education, and Welfare, Department of, Elmer W. Smith, Associate Commissioner for Program Policy and Planning, letter to Congressman Vanik ... 130
Health Planning and Development Council for Broward County (Fla.), Sandra J. Fahey, statement ... 258
Hillside Community Hospital of Ukiah, Shirley Ann Munroe, mailgram forwarded by Congressman Don H. Clausen ... 259
Holder, Walter, Ph. T., Massachusetts Society of Registered Physical Therapists, letter ... 286
Hollywood Memorial Hospital, Hollywood, Fla., Jean Rifkin, statement ... 258
Information and Referral for the Elderly, Ft. Lauderdale, Fla., Ruby Felder Powell, statement ... 258
Insurance Association of Connecticut, Roger Dove, statement ... 260
Kaiser Foundation Health Plan, Inc., James A. Lane, letter and statement ... 262
Kemp, Merlin L., Ph. T., Golden State Physical Therapy Association of California, Inc., letter ... 286

Page
Lane, James A., Kaiser Foundation Health Plan, Inc., letter and statement 262
Lakin, Sally, Special Gerontology Project, Ft. Lauderdale, Fla., statement 258
Leventhal, Alan, Ph. T., United Societies of Physiotherapists, Inc., letter 286
Massachusetts Society of Registered Physical Therapists, Walter Holder, Ph. T., letter 286
McGee, James J., Wills Eye Hospital, letter with enclosure 288
Mendocino Community Hospital, Governing Board, resolution, forwarded by Congressman Don H. Clausen 268
Michigan, University of, School of Public Health, program and bureau of hospital administration, John R. Griffith, statement 277
Munroe, Shirley Ann, Hillside Community Hospital of Ukiah, mailgram forwarded by Congressman Don H. Clausen 259
National Council of Senior Citizens, Inc., Nelson H. Cruikshank, statement 268
National Council of State Public Welfare Administrators, American Public Welfare Association, R. Archie Ellis and William Stewart, M.D., statement 275
New Jersey State Physical Therapy Society, Inc., Patrick Trotta, Ph. T., letter 286
Pennsylvania, Physical Therapy Society of, Alwen DeWald, letter 286
Powell, Ruby Felder, Information and Referral for the Elderly, Ft. Lauderdale, Fla., statement 258
Rhode Island Physical Therapy Society, Inc., Mildred Doane, Ph. T., letter 286
Rifkin, Jean, Hollywood Memorial Hospital, Hollywood, Fla., statement 258
Sammons, James H., M.D., American Medical Association, letter 235
St. Elizabeth's Hospital of Boston, William J. Skerry, letter forwarded by Congressman James A. Burke 284
Service Agency for Senior Citizens, Ft. Lauderdale, Fla., Bruce Slipock, statement 258
Skerry, William J., St. Elizabeth's Hospital of Boston, letter forwarded by Congressman James A. Burke 284
Slipock, Bruce, Service Agency for Senior Citizens, Ft. Lauderdale, Fla., statement 258
Special Gerontology Project, Ft. Lauderdale, Fla., Sally Lakin, statement 258
Stewart, William, M.D., National Council of State Public Welfare Administrators, American Public Welfare Association, statement 275
Trotta, Patrick, Ph. T., New Jersey State Physical Therapy Society, Inc., letter 286
United Societies of Physiotherapists, Inc., Alan Levanthal, Ph. T., letter 286
West Virginia Committee for the Health Security Act, statement 287
Wills Eye Hospital, James J. McGee, letter with enclosure 288

Wednesday, September 15, 1976 (Pages 291–508)

RECOMMENDATIONS RELATING TO REVISIONS IN THE MEDICARE REIMBURSEMENT SYSTEM

Press release of Thursday, July 22, 1976, announcing hearing on recommendations relating to revisions in the medicare physician reimbursement system 292
Committee print "Reasonable Charge Reimbursement for Physicians' Services Under Medicare" 295

Witnesses

Ament, Richard, M.D., American Society of Anesthesiologists 376
American Academy of Family Physicians, Allan H. Bruckheim, M.D., and Carl B. Hall, M.D 369
American Academy of Physicians' Assistants, Thomas R. Godkins and Donald W. Fisher 392
American Medical Association, Raymond T. Holden, M.D., Edgar T. Beddingfield, Jr., M.D., and Harry N. Peterson 333
American Osteopathic Association, George J. Luibel, D.O., and John P. Perrin 389

Page
American Society of Anesthesiologists, John W. Ditzler, M.D., Richard Ament, M.D., and Michael Scott 376
Beddingfield, Edgar T., Jr., M.D., American Medical Association 333
Bruckheim, Allan H., M.D., American Academy of Family Physicians 369
Ditzler, John W., M.D., American Society of Anesthesiologists 376
Fisher, Donald W., American Academy of Physicians' Assistants 392
Godkins, Thomas R., American Academy of Physicians' Assistants 392
Hall, Carl B., M.D., American Academy of Family Physicians 369
Holden, Raymond T., M.D., American Medical Association 333
Kenneth, Robert J., Kenneth Associates, San Francisco, Calif 418
Luibel, George J., D.O., American Osteopathic Association 389
Morderosian, Lawrence D., Portland, Oreg 404
Morris, Lawrence C., National Association of Blue Shield Plans 360
National Association of Blue Shield Plans, Lawrence C. Morris 360
Perrin, John P., American Osteopathic Association 389
Peterson, Harry N., American Medical Association 333
Scott, Michael, American Society of Anesthesiologists 376
Symington, Hon. James W., a Representative in Congress from the State of Missouri 306
Thornton, Hon. Ray, a Representative in Congress from the State of Arkansas 320

MATERIAL SUBMITTED FOR THE RECORD

Social Security Administration, Thomas M. Tierney, Director, Bureau of Health Insurance, correspondence regarding reimbursement rates of New York City area 433
Aetna Life & Casualty, Robert E. Stewart, statement 443
American Academy of Family Physicians, Kentucky chapter, Paul J. Sides, M.D., letter and resolutions 444
American Academy of Physician's Assistants, Jarrett M. Wise, letter forwarded by Congressman Vanik 445
American Association of Neurological Surgeons, Robert G. Ojemann, M.D., Lester A. Mount, M.D., Louis A. Finney, M.D., Russel H. Patterson, M.D., Donald H. Stewart, Jr., M.D., and Charles A. Fager, M.D., statement 446
American Association of Retired Persons and the National Retired Teachers Association, statement 486
American Dental Association, statements 452
American Federation of Labor and Congress of Industrial Organizations, statement 450
American Society for Medical Technology, statement 459
American Society of Internal Medicine, statements 472
Asay, Ivan, West Virginia Committee for the Health Security Act, statement 505
Cruikshank, Nelson H., National Council of Senior Citizens, statement 489
De La Garza, Alexander M., M.D., Medical Society of the County of Queens, Inc., letter forwarded by Congressman Wolff M 441
Ellithorpe, Charles T., M.D., North Mecklenburg Family Practice Group, letter 477
Fager, Charles A., M.D., American Association of Neurological Surgeons, statement 446
Finney, Louis A., M.D., American Association of Neurological Surgeons, statement 446
Fisher, Peter, Santa Barbara, Calif., statement 477
Health Insurance Association of America, statement 481
Howard, Jerome, M.D., North Mecklenburg Family Practice Group, letter 485
Medical Society of the County of Queens, Inc., Alexander M. De La Garza, M.D., letter forwarded by Congressman Wolff M 441
Mount, Lester A., M.D., American Association of Neurological Surgeons, statement 446
National Council of Senior Citizens, Nelson H. Cruikshank, statement 489
National Retired Teachers Association and the American Association of Retired Persons, statement 486
North Mecklenburg Family Practice Group:
  Jerome Howard, M.D., letter 485
  Charles T. Ellithorpe, M.D., letter 477

Page
Ojemann, Robert G., M.D., American Association of Neurological Surgeons, statement 446
Patterson, Russel H., M.D., American Association of Neurological Surgeons, statement 446
Runyan, John W., Jr., M.D., Memphis, Tenn., letter with enclosure 494
Sides, Paul J., M.D., American Academy of Family Physicians, Kentucky chapter, letter and resolutions 444
Smith, Eugene E., Wichita, Kans., letter forwarded by Congressman Garner E. Shriver 499
Stewart, Donald H., Jr., M.D., American Association of Neurological Surgeons, statement 446
Stewart, Robert E., Aetna Life & Casualty, statement 443
Wallace, Samuel B., Washington, D.C., petition 499
Ward, Charles S., R.N.-P.A., Clairfield, Tenn., letter with enclosures 500
West Virginia Committee for the Health Security Act, Ivan Asay, statement 505
Wise, Jarrett M., American Academy of Physician's Assistants, letter forwarded by Congressman Vanik 445

Thursday, September 16, 1976 (Pages 509–609)

MEDICARE POLICY RELATING TO REIMBURSEMENT OF PHYSICIANS IN TEACHING HOSPITALS

Press release of Wednesday, August 4, 1976, announcing hearing on medicare policy relating to reimbursement of physicians in teaching hospitals 510
Committee print "Medicare Reimbursement for Services of Physicians in Teaching Hospitals" 512

Witnesses

Social Security Administration, Bureau of Health Insurance, Thomas M. Tierney, Director, Al Diamond, Deputy Director, and Clifton Gaus, Office of Research and Statistics 568
Association of American Medical Colleges, David D. Thompson, M.D., J. Robert Buchanan, M.D., and Richard M. Knapp 577
Ball, Robert, Institute of Medicine, National Academy of Sciences 543
Buchanan, J. Robert, M.D., Association of American Medical Colleges 577
Derzon, Robert, Institute of Medicine, National Academy of Sciences 543
Hamburg, David A., M.D., Institute of Medicine, National Academy of Sciences 543
Hanft, Ruth, Institute of Medicine, National Academy of Sciences 543
Institute of Medicine, National Academy of Sciences, David A. Hamburg, M.D., Prof. Adam Yarmolinsky, Robert Ball, Robert Derzon, and Ruth Hanft 543
Knapp, Richard M., Association of American Medical Colleges 577
Thompson, David D., Association of American Medical Colleges 577
Yarmolinsky, Prof. Adam, Institute of Medicine, National Academy of Sciences 543

Material Submitted for the Record

Ainsworth, Thomas H., Jr., M.D., Illinois Masonic Medical Center, statement 605
American Hospital Association, statement 596
American Osteopathic Hospital Association, Michael F. Doody, letter 600
Association of University Radiologists, Robert D. Moseley, Jr., M.D., letter 601
Blue Cross Association, Neil Hollander, statement 603
Doody, Michael F., American Osteopathic Hospital Association, letter 600
Hollander, Neil, Blue Cross Association, statement 603
Illinois Masonic Medical Center, Thomas H. Ainsworth, Jr., M.D., statement 605
Moseley, Robert D., Jr., M.D., Association of University Radiologists, letter 601

RECOMMENDATIONS RELATING TO REVISIONS IN THE MEDICARE HOSPITAL REIMBURSEMENT SYSTEM

TUESDAY, AUGUST 3, 1976

House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice in room B-316, Rayburn House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The Subcommittee on Health will come to order.

As I have tried to make clear in the press release announcing this hearing, the subcommittee's intent is to receive information and recommendations on the issues that will need to be addressed in the formulation of a revised hospital reimbursement system under medicare. The critical need for a reassessment of the present reimbursement system is evident to all. The subcommittee's press release discusses in detail the reasons for our concern.

Suffice it to say that our current reasonable cost system of payment for institutional services under medicare has been widely criticized for failing to provide incentives for cost containment and, therefore, contributing to the escalation of hospital costs. In consequence, many people have come to the conclusion that prospective, rather than retrospective, establishment of reimbursement levels offers much greater potential for containing hospital cost increases by facilitating more responsible financial planning. The question that most immediately confronts us, however, is how to translate the concept of prospective reimbursement into a comprehensive and systematic approach to the setting of reimbursement levels.

It should be noted that this subcommittee is not alone in focusing increased attention on the medicare reimbursement system. Other congressional committees, including the Senate Finance Committee, have addressed themselves in public hearings to various facets of this issue. The Ways and Means Oversight Subcommittee has been conducting hearings on the progress and results of the experimentation with alternative prospective reimbursement approaches mandated by the Social Security Amendments of 1972. And, the administration in earlier testimony before this subcommittee has similarly made known its concern about the shortcomings of our present reimbursement system and the need for a concerted effort to bring about effective reforms. All of this testifies to a growing and widespread realization that the time has come for intensive analysis of the specific issues involved in restructuring the medicare reimbursement system. It is my hope this hearing will advance that objective and contribute to the development of sound legislative proposals.

At this time, I ask unanimous consent that the press release announcing this hearing and a background document prepared by the subcommittee staff be included in the record.

[Press release and document follow:]

[Press release of Thursday, June 24, 1976]

HON. DAN ROSTENKOWSKI (D., ILL.), CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCES A 1-DAY HEARING ON RECOMMENDATIONS RELATING TO REVISIONS IN THE MEDICARE HOSPITAL REIMBURSEMENT SYSTEM TO BE CONDUCTED TUESDAY, AUGUST 3, 1976

The Honorable Dan Rostenkowski (D., Ill.), Chairman of the Subcommittee on Health of the Committee on Ways and Means announced today that the Subcommittee will hold a one-day hearing on the issues involved in rising hospital costs and possible revisions in the present retrospecive cost reimbursement system used in the medicare program. This hearing will begin at 9:00 a.m. on Tuesday, August 3, 1976, and will be conducted in the Committee's Main Hearing Room, Longworth House Office Building unless the Committee's schedule at that time necessitates a change of location. A discussion of the specific issues to be considered at this hearing appears below. The hearing will not cover any other subjects or issues. Witnesses will be required to confine their testimony to a discussion of the issues described below and to a precise, detailed explanation of the specific recommendations they are prepared to make for changes in the present medicare hospital reimbursement system.

BACKGROUND INFORMATION REGARDING THE HEARING TOPIC

The rising cost of hospital care continues to be the major factor driving up medicare expenditures. Yet an underlying premise of most recent discussion about this problem is that much of it is attributable to medicare itself, to the adoption by medicare of retroactive cost-based reimbursement. This view was expounded, for example, by former HEW Secretary Weinberger in his testimony before the Subcommittee on June 12, 1975, during which he said:

"I . . . firmly believe that the faulty design of medicare and medicaid is the principal culprit responsible for . . . inflation in health care costs. [W]ith The guaranteed government payment of health care costs in virtually any amount submitted by the provider, and with normal market factors absent in the health care area, inflation was bound to happen, and it did."

Proponents of this view hold that the method of retrospective cost reimbursement encourages hospitals to spend freely—since whatever costs are incurred tend to be reimbursed as "reasonable costs"—and leads necessarily to the proliferation and inefficient employment of facilities, over-consumption of services, and a general lack of cost consciousness among consumers and providers.

General dissatisfaction with this situation has given rise to considerable discussion of and experimentation with so-called "prospective reimbursement" approaches under which attempts are made to set rates of payment for a given period into the future. The Congress, in the 1972 amendments to the Social Security Act, reflected the prevailing concern by mandating experimentation with different types of prospective reimbursement. While the basic idea of prospective reimbursement—that incentives for efficiency and the elimination of unnecessary services can be introduced by letting a hospital know its payment rate before it renders its services—has much intuitive appeal and is widely acclaimed, the idea has yet to be translated into a comprehensive and systematic approach to the setting of rates of payment.

SPECIFIC ISSUES TO BE ADDRESSED BY WITNESSES

The Subcommittee desires to receive information and recommendations on a series of specific issues that will need to be addressed in the formulation of a reformed system of hospital reimbursement under medicare. Witnesses are invited to address any or all of the following topics:

1. Factors contributing to the continuing rise in the costs of hospital care.
2. Results of the most recent analyses of experience under alternative prospective reimbursement approaches, including State hospital rate regulation.
3. The role of State rate regulation in a revised medicare hospital reimbursement system.
4. Alternative approaches to setting prospective rates, including recommendations regarding specific issues such as the extent to which retroactive adjustments should be permitted, the unit of payment to be used (e.g., per case, per diem), the need for uniform accounting, reporting and cost allocation systems for health care institutions, the financial incentives to providers for achieving costs savings, and the disposition of incentive payments.
5. The feasibility and desirability of providing to hospitals a choice among more than one reimbursement methodology; the conditions under which it might be desirable to recognize and reimburse in accordance with a State rate-setting program that meets specified criteria.
6. Special provisions relating to control of capital expenditures; relationship to the health planning process established by P.L. 93–641.
7. Issues related to the administrative implementaiton of a prospective reimbursement system; e.g., phasing in various elements of the system; application of the system to different types of providers.
8. Comments on legislation introduced in this Congress (or in a previous Congress) to reform medicare hospital reimbursement, such as S. 3205 (Talmadge) and its House counterpart, H.R. 13080 (Duncan of Tennessee).
9. Considerations for and against imposing, prior to the full implementation of a prospective reimbursement system, a ceiling on total hospital cost increases recognized as reasonable by medicare; methods for establishing such a ceiling and for recognizing and allowing exceptions to the ceiling.
10. Other data or recommendations that will assist the Subcommittee in its consideration of revised reimbursement methodology.

ALLOCATION OF TIME TO WITNESSES

In view of the limited time available for this hearing, it will be necessary to allocate the amount of time available to each witness for presentation of his direct oral testimony. The witnesses' full statements, as well as any additional materials they would like to submit, will be included in the record of the hearing.

CUTOFF DATE FOR REQUESTS TO BE HEARD

Requests to be heard must be received by the Committee no later than the close of business Friday, July 23, 1976. Requests should be addressed to John M. Martin, Jr., Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515, telephone (202) 225–3625. Notification of a witness' scheduled appearance will be made as promptly as possible after the cutoff date. If a witness finds that he cannot appear, he may wish to either substitute another spokesman or file a written statement for the record.

Any interested person or organization may, instead of a personal appearance, file a written statement for inclusion in the printed record of the hearing. For this purpose, statements should be submitted in triplicate by the close of business, Tuesday, August 3. Additional copies may be furnished for distribution to the members of the Committee, the staff, press and interested public, if submitted to the Committee during the course of the public hearing.

REQUESTS TO BE HEARD MUST CONTAIN THE FOLLOWING INFORMATION

1. The name, full address, and capacity in which the witness will appear.
2. A list of persons or organizations the witness represents.
3. A topical outline or summary of the comments and recommendations which the witness proposes to make, such outline or summary to indicate in sufficient detail the nature of the specific recommendations for medicare reimbursement changes the witness intends to make.

Persons scheduled to appear before the Subcommittee to testify at this hearing must submit 75 copies of their prepared statements to the Committee office no later than 24 hours prior to their scheduled appearance. An additional 50 copies may be furnished for distribution to the press and the interested public on the date of appearance.

94th Congress }
2d Session }

COMMITTEE PRINT

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

COST-BASED REIMBURSEMENT OF HOSPITALS UNDER MEDICARE

ALTERNATIVES AND ISSUES

JULY 29, 1976

Prepared by the staff for use by the Subcommittee on Health, House
Committee on Ways and Means, with the assistance of the
Congressional Research Service, Library of Congress

U.S. GOVERNMENT PRINTING OFFICE
74-437 WASHINGTON : 1976 WMCP: 94-139

COMMITTEE ON WAYS AND MEANS

AL ULLMAN, Oregon, *Chairman*

WILBUR D. MILLS, Arkansas
JAMES A. BURKE, Massachusetts
DAN ROSTENKOWSKI, Illinois
PHIL M. LANDRUM, Georgia
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
JAMES C. CORMAN, California
WILLIAM J. GREEN, Pennsylvania
SAM M. GIBBONS, Florida
JOE D. WAGGONNER, Jr., Louisiana
JOSEPH E. KARTH, Minnesota
OTIS G. PIKE, New York
RICHARD F. VANDER VEEN, Michigan
J. J. PICKLE, Texas
HENRY HELSTOSKI, New Jersey
CHARLES B. RANGEL, New York
WILLIAM R. COTTER, Connecticut
FORTNEY H. (PETE) STARK, California
JAMES R. JONES, Oklahoma
ANDY JACOBS, Jr., Indiana
ABNER J. MIKVA, Illinois
MARTHA KEYS, Kansas
JOSEPH L. FISHER, Virginia
HAROLD FORD, Tennessee

HERMAN T. SCHNEEBELI, Pennsylvania
BARBER B. CONABLE, Jr., New York
JOHN J. DUNCAN, Tennessee
DONALD D. CLANCY, Ohio
BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
WILLIAM A. STEIGER, Wisconsin
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
JAMES G. MARTIN, North Carolina
L. A. (SKIP) BAFALIS, Florida
WILLIAM M. KETCHUM, California

John M. Martin, Jr., *Chief Counsel*
J. P. Baker, *Assistant Chief Counsel*
John K. Meagher, *Minority Counsel*

Subcommittee on Health

DAN ROSTENKOWSKI, Illinois, *Chairman*

JAMES C. CORMAN, California
OTIS G. PIKE, New York
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
JOE D. WAGGONNER, Jr., Louisiana
WILLIAM R. COTTER, Connecticut
MARTHA KEYS, Kansas

JOHN J. DUNCAN, Tennessee
PHILIP M. CRANE, Illinois
JAMES G. MARTIN, North Carolina
DONALD D. CLANCY, Ohio

COST-BASED REIMBURSEMENT OF HOSPITALS UNDER MEDICARE

I. Background

1. *Introduction*

Under medicare, payments to hospitals are made on the basis of the cost of providing covered services to program beneficiaries. Cost reimbursement involves determinations, in accordance with established cost principles, of the actual costs incurred by the facility in the rendering of patient care. Payments are made at periodic intervals based on estimated operating costs with retroactive adjustments made for each accounting period.

This retrospective cost-based reimbursement mechanism has come under increasing criticism in recent years and has even been cited as one of the contributors to the inflationary pressures on health care costs. Specifically, this method of paying for hospital care is viewed as inflationary because: (1) it fails to set effective limits on the costs that are recognized as reasonable; and (2) it fails to offer incentives for efficient performance or, alternatively, to create disincentives for inefficient operation. Proponents of this view argue that medicare's method of cost reimbursement encourages hospitals to spend freely—since whatever costs are incurred are generally reimbursed as "reasonable." This allegedly contributes to the proliferation and inefficient employment of facilities, overconsumption of services, and a general lack of cost-consciousness among both the consumers and providers of hospital services. Dissatisfaction with medicare's payment system has given rise to considerable discussion of and experimentation with alternative reimbursement approaches.

This document discusses alternative reimbursement mechanisms, and raises some of the policy questions relating to changing medicare's present basis for paying for hospital care.

2. *Current hospital reimbursement system*

Present law provides that, except for certain deductible and coinsurance amounts which must be paid by program beneficiaries, payments to hospitals shall be made on the basis of the "reasonable cost" of providing covered services. Under the program, reasonable costs are those costs actually incurred in delivering health services, excluding any part of such incurred costs found to be unnecessary for the efficient delivery of needed health services. The Secretary of Health, Education, and Welfare is required to issue regulations establishing the method or methods to be used and the items to be included, in determining the "reasonable cost" of covered care. In developing these regulations, the Secretary is directed to consider the principles and the methods utilized by national organizations in determining the amounts of payments. Costs may be determined on a per diem, per unit, per capita or other basis, may provide for the estimates of certain costs and may provide for the use of charges or a percentage of charges where this method reasonably reflects the cost. In addition, the Secretary is required to apportion the costs of services provided by hospitals between beneficiaries and other patients to assure that medicare pays all of the reasonable costs of services attributable to program beneficiaries and only those costs.

To carry out the congressional mandate, HEW developed regulations establishing the framework of hospital reimbursement under medicare. These regulations:

(1) Identify "allowable costs"—the items or elements of providers' actual costs, both direct and indirect, which are reimbursable under the program; these costs must be reasonable and must relate to patient care.

(2) Provide methods of cost apportionment—determining what portion of total allowable costs of a hospital can be attributed to medicare beneficiaries and therefore be reimbursed under the program.

(3) Provide methods of cost finding—determining what the total actual cost is of providing services.

(4) Provide methods for making payments to providers.

For a number of years, Congress and other interested parties have been concerned that this retrospective cost-reimbursement mechanism does not provide incentives for cost control or efficiency of operations. The Social Security Amendments of 1967 included an amendment which authorized the Secretary of HEW to engage in experiments with different methods of reimbursement to institutions. It was hoped that experimentation with other reimbursement methods would provide a reliable basis for making changes in the reimbursement system that would introduce incentives to reduce or moderate hospital costs.

In 1972, the Congress again authorized experimentation with alternate methods of cost reimbursement, but specifically encouraged experimentation with prospective reimbursement. This is a method of setting a facility's reimbursement level in advance of the covered period. Experiments with prospective reimbursement systems are now underway in the medicare program.

In the 94th Congress, several measures have been introduced which would place limits on increases in hospital costs recognized as reasonable.

The administration proposal (H.R. 12082, Mr. Duncan of Tenn.) would limit overall reimbursement increases to 7 percent per year for each institution. Another proposal (S. 3205, Senator Talmadge) would establish, among other things, limits upon certain routine operating costs.

II. Alternatives to Retrospective Cost Reimbursement

General dissatisfaction with medicare's present cost-based reimbursement system has led to considerable discussion and experimentation with alternative approaches to paying for hospital care. These alternatives are frequently described as "prospective reimbursement," an approach which the Social Security Administration defines as ". . . the financial remuneration of health care providers whereby the amount or rate to be paid is established prior to the period over which the rate is to be applied."

3

Significant advantages are attributed to prospective reimbursement by proponents of this approach. It is argued, for example, that if a hospital could know its payment rate before it rendered its services, it would have the highest possible motivation to see that these services were produced in the most efficient manner, since its solvency would depend on keeping its spending within the limits of its anticipated revenues. An additional positive incentive for efficiency could also be provided if, for example, provision were made for allowing a hospital which produces its service more cheaply than the predetermined rate to retain part or all of the difference.

Prospective reimbursement systems may be characterized in terms of three major characteristics:

(1) The method of establishing a rate of payment;
(2) The unit of payment to be used; and,
(3) The type of incentive used, if any.

Within each of these components of reimbursement, a number of alternatives are available.

1. *Methods of determining the rates of payment*

The method of determining the rate of payment refers to the procedure used in establishing the rate. The principal methods which have been suggested are as follows:

(1) *Budget review and approval.*—Budget review and approval involves the setting or approval of reimbursement rates based on detailed examination of the budgets of individual hospitals and their departments. This method includes two widely discussed variations:

—*prospective budgeting* in which the needs of each hospital department are assessed for a prospective period of time. As a result of this examination, areas of possible savings are noted and an overall target budget is prepared for each department and for the hospital as a whole. Reimbursement is based on the target budget, and can include positive or negative incentives for meeting or not meeting the targeted amount.

—*rate review, or rate setting* involves reviewing or establishing the rates to be charged by hospitals based on a detailed examination of past and projected budgets of the hospitals. Rate setting agencies attempt to assure that hospital costs are reasonably related to services performed, that aggregate revenues are reasonably related to aggregate costs, and that the hospital's rates are established equitably for all purchasers.

Prospective budgeting focuses more directly on the decisionmaking process within each individual hospital and its departments, while in rate setting, attention focuses specifically upon the rates to be paid the hospitals.

(2) *Negotiated rates.*—The negotiation method involves joint decisionmaking between hospitals and rate-setting organizations, allowing hospitals to attempt to justify their financial requirements, and the rate setters to attempt to decrease requests that seem high. There are similarities between this method and the budget review and approval method, which may also involve negotiation.

(3) *Formula methods.*—These methods involve the use of formulas to determine rates of payment. Currently, most formula approaches are limited to establishing ceilings or target rates under cost-based

reimbursement systems, although the formula approach has been used to establish prospective payment rates. The wide range of rate determinations made under a formula approach include the following:

—predetermined percentage ceilings such as the 7 percent "cap" on hospital cost increases proposed by the administration;

—formulas establishing ceilings based on some normative standard such as a ceiling set at some specific percentile of hospital costs, similar to the current limitation applied under medicare; and,

—formulas establishing ceilings or reimbursement rates based on the analysis and quantification of more complex factors associated with the production of hospital services such as the system currently used in New York.

Formulas can be used with a budget review and approval method, both to provide absolute ceilings within which the process must operate and to provide screens for the analysis of particular budget items. Formulas can also be used as part of a negotiation process.

2. *Units of payment*

Any reimbursement system must identify the unit on the basis of which payment will be made. Currently, the most common basis for reimbursement is the day of care. Payment units which have been suggested as alternative bases for payment under prospective reimbursement proposals include the following:

(1) Total hospital budget (total hospital cost);
(2) Departmental budgets (total departmental costs);
(3) Family or person (capitation);
(4) Episode of illness;
(5) Case or stay; and
(6) Specific service.

The first three units (total hospital budgets, departmental budgets, and family or person) provide for reimbursement which is only indirectly related to the hospital's output, since the rate established does not vary with the quantity of service provided. The other three units would provide reimbursement directly related to the quantity of service provided by the hospital.

3. *Incentives*

A third aspect of prospective reimbursement systems is the nature of the incentives that are provided to encourage efficiency. Incentives can be of two types:

(1) Positive incentives offering financial gains to the institution, and

(2) Negative incentives exposing the institution to potential penalties.

Positive incentives in a prospective reimbursement system generally take the form of allowing hospitals to retain a portion of the excess revenues if actual costs are below the payment rate projected for them. Negative incentives operate in the opposite manner, forcing hospitals to absorb some of the excess costs if their actual costs are higher than the payment rate projected for them.

III. Medicare Hospital Reimbursement Issues

1. *Practicality and effectiveness of alternatives*

Background

One version of the formula approach to setting hospital rates prospectively is to evaluate the reasonableness of a hospital's costs by comparing them to the costs of similar hospitals. Other formulas use economic indicators and other standards to determine how much of an increase in a hospital's costs will be approved. On the other hand, the budget review method of setting rates puts the reimbursement reviewer in the position of second guessing the hospital administration about the amount that will be needed for the efficient operation of the institution. Whichever method is used, the hospital can be given an incentive to operate efficiently by rewarding the institution if its actual costs turn out to be less than the amount that had been set initially.

Issues

(1) What evidence is there that prospective rate reimbursement has been successful in containing costs?

(2) Is it possible to devise a formula for establishing reimbursement rates prospectively that will not unfairly benefit or disadvantage hospitals with atypical costs? For example, what consideration should be given to such variables as: a hospital's geographic location (e.g., one with unusually high- or low-salary levels or energy costs); the intensity of care required by its patients; the quality of the care provided?

(3) If a prospective rate system were adopted that is based on the review of individual hospital budgets, would it be possible to develop guidelines that would make the expertise and subjective judgment of the respective reviewers a relatively unimportant factor in decisions about the validity of proposed hospital expenditures?

(4) Would it be feasible to hire and pay personnel in the numbers, and with the expertise, needed to review the budgets of the some 7,000 hospitals that participate in medicare?

(5) What special administrative, recordkeeping, and management demands would a prospective rate system place on hospitals?

(6) Should there be situations where the prospective rate once set should be changed—for example, where a hospital's costs are unexpectedly increased by a surge of inflation, an increase in its wage costs, an epidemic, and so forth?

(7) Do financial rewards paid to an institution provide a sufficient additional incentive to its administrators to economize to warrant the cost?

(8) Should special provision be made for the hospital that is essential to the community it serves if its financial solvency is threatened because its costs have exceeded the rates set for it?

2. *Impact on hospital behavior*

Background

A prospectively established payment rate can be quantified in a number of ways. For example, it can be stated in terms of a fixed amount per day of care without regard to the nature of the services the patient receives. Or a flat payment can be made for each patient who is admitted, without regard to the nature of services he receives or how long he stays in the hospital. Another approach medicare could utilize is to approve the budget of a hospital or its departments at a fixed dollar level and then pay the institution a proportionate share of the approved amount—for example, medicare could pay one-fourth of the approved budget amount if medicare patients received one-fourth of the services the hospital provided.

Whatever payment unit is used, financial incentives will be created that will tend to influence the hospital to modify its admission, patient care, and administrative policies and practices either to reduce costs to the level that will be fully reimbursed or to earn an incentive payment.

In some cases these incentives will operate in a beneficial manner while in other cases they may not.

If reimbursement were based on a fixed dollar amount per day, for example, a hospital would find it to its advantage to cut back on the services it provides. If this were accomplished by eliminating underutilized services that can be provided more efficiently in other local hospitals, one of the objectives of a prospective reimbursement system would be achieved. If the lower costs were realized by limiting admissions to patients who need a less intensive level of care—for example, long-term care patients—medicare would not benefit, since the more costly patients would still be cared for by other hospitals at the program's expense. And if the hospital lowered its costs by providing less care than is appropriate, the effect of the prospective rate system could be lower quality of care.

In short each of different possible payment units that could be employed create somewhat different incentives. Therefore, any prospective rate proposal should be examined from the standpoint of its possible impact on: the number of patients treated; length of stay; characteristics of patients admitted; and the intensity and scope of services provided.

Issues

(1) To what degree would hospitals be influenced to take undesirable actions to reduce their costs under a prospective rate system?

(2) Are special safeguards needed to prevent a hospital from benefiting from changes that merely shift costs to other institutions?

(3) Would the existing quality control mechanisms (PSRO's and hospital utilization review committees) provide adequate assurance that prospective reimbursement will not impair quality of care?

(4) Should a prospective reimbursement system, if adopted, be put into effect on a limited basis (e.g., in only certain localities) to further test its effects?

3. *Relationship with other third parties*

Background

Medicare is one of the major purchasers of hospital care, but is by no means the only one. State medicaid programs, Blue Cross plans, commercial insurance companies, and private patients also pay significant amounts for hospital care.

Each of these purchasers may use a different basis for reimbursing hospitals. For example, currently, in any one hospital, the medicare program and Blue Cross may pay costs using different formulas, and commercial insurers and private patients pay charges; in some cases, Blue Cross may be experimenting with a prospective reimbursement plan. These diverse sources of revenues provide hospitals with both problems and opportunities. The problems include different administrative and reporting requirements, and the possibility that inadequacies in payments from one purchaser may force the hospital to seek compensatory adjustments from others. The opportunity presented is that the hospital can attempt to maximize reimbursement from all purchasers.

Introduction of a prospective mechanism under medicare would tend to compound these problems unless certain basic issues are resolved. Especially important is the finding of the Social Security Administration that a prospective payment mechanism would not be fully viable unless all payers are included. The issues involved include the effectiveness of prospective reimbursement if other third parties are not included among the various purchasers and the problems of getting other third parties to participate.

Issues

(1) Can a prospective reimbursement system under medicare be effective in controlling increases in hospital costs if other third party payers are not included in the system?

(2) What problems arise if other third party payers are not included in the system? To what extent would hospitals either:

(*a*) make up "losses" incurred as a result of the prospective reimbursement under medicare by seeking increased reimbursement from other sources?

(*b*) subsidize other third party payers with "gains" resulting from prospective reimbursement?

(3) How is it possible to get other third parties to participate? Should medicare tie into existing area or State mechanisms as they are developed, or take a more active role in developing participation by other third parties?

(4) What are the implications of mandating participation by other third parties in a prospective reimbursement mechanism? How could this be done?

4. *Financing modernization and expansion*

Background

Medicare and other health benefit programs have fostered hospital growth by reimbursing hospitals for the depreciation of their facilities and equipment. Hospitals are also reimbursed for interest they pay on money borrowed to finance such capital expenditures. Thus, if a hospital borrows money (or sells bonds) to finance a modernization or expansion project, the depreciation payments may be used to repay the principle, and the borrowing costs are reimbursed as they are incurred. The hospital may use depreciation payments for any purpose it chooses. Thus, a hospital that is not in debt can invest the payments, or use them to finance current operating costs.

The substantial increases in hospital costs over the past several years have focused attention on the excessive number of hospital beds and unnecessarily duplicative equipment and facilities in some areas of the Nation. These excesses are expensive to establish initially and they are expensive to staff and maintain thereafter. Also, in part because they are a source of revenue to the hospital and its physicians when used and a liability when not used, they invite overutilization and uneconomical patient care. To help prevent the use of Federal funds to support unwarranted capital expenditures, the Secretary of HEW is authorized to withhold medicare depreciation and interest payments related to capital expenditures that are inconsistent with State and local health facility plans. (The Secretary has similar authority and respect to the Federal share of depreciation and interest payments under medicaid and the maternal and child health programs.)

Since a hospital's capital requirements should be taken into account in any hospital reimbursement system, the following issues are pertinent whether the system calls for the setting of reimbursement rates on a prospective or retroactive basis.

Issues

(1) Should payment of depreciation and interest amounts be made subject to Federal standards or priorities in addition to State approval?

(2) Should the Federal Government continue to follow the policy of making depreciation payments with respect to facilities and equipment that were paid for with Federal funds?

(3) Should a hospital that is not in debt be required to fund the depreciation payments its receives so that it will not have to borrow and pay interest when it modernizes or expands in the future?

(4) Should depreciation payments to hospitals that do not need them to repay loans be pooled and used as an interest-free source of funds for hospitals that do need to make capital expenditures?

(5) Should funds beyond those now available be provided by medicare to hospitals to help them make improvements that will ultimately reduce medicare expenditures by making the hospitals more efficient?

(6) Should additional funds be made available to help hospitals close down underutilized facilities?

Mr. Rostenkowski. Our first witness this morning will be John Alexander McMahon, and Leo J. Gehrig, senior vice president, American Hospital Association.

Welcome to the subcommittee, gentlemen. Will you identify yourselves and proceed with your testimony?

STATEMENT OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY LEO J. GEHRIG, SENIOR VICE PRESIDENT

Mr. McMahon. Good morning, Mr. Chairman. I am Alex McMahon representing the American Hospital Association, representing more than 7,000 member institutions, including most of the hospitals in the country, extended and long-term care institutions, mental health facilities, hospital schools of nursing, and over 21,000 personal members. With me today is Leo J. Gehrig, M.D., senior vice president of the association.

We appreciate this opportunity to present the views and recommendations of the association. We have carefully reviewed your announcement of these hearings and the nine specific issues you wish to have witnesses address. Our testimony discusses these points not in the order of your listing, but under three major headings:

Hospital Cost Experience.

Current Proposals to Limit Hospital Reimbursement.

Prospective Reimbursement Approaches.

In our discussion of prospective reimbursement approaches, we review and make specific recommendations on the hospital reimbursement provision of H.R. 13080, introduced by Representative John Duncan, which is before this committee.

HOSPITAL COST EXPERIENCE

The ballooning of funds spent for hospital care in the late 1960's represented a sharp increase in the demand for hospital services over slowly rising growth in the hospital economy since the end of World War II. Medicare and medicaid are the two major contributors to this increase, as they are aimed at two groups which have disproportionately more health problems and thus are heavier users of hospital services.

The explosion in demand, stemming largely from reduction in out-of-pocket consumer costs for hospital services after the introduction of medicare and medicaid, as well as the growth of private health insurance, including an increasing coverage of catastrophic illness, resulted in an unprecedented rate of accumulation and employment of resources to care for rising numbers of patients. During the 4 years from 1966 to 1969, the hospitals' share of the GNP increased nearly 25 percent. The demand for hospital services, however, like the demand for any commodity or service, has natural limits. Thus, time softened the thrust of increased demand.

As measured by hospital unit (per day and per admission) costs, the effects of the medicare and medicaid induced bulge in demand had begun to subside by 1970. Cost increases were slowed even further by mandatory wage and price controls in August of 1971. The rates of increase in total hospital expenditures and unit costs during the 990 days of continuous controls on the health industry approached pre-medicare (1965) levels. That is before the midsixties.

Unfortunately, the perpetuation of mandatory wage and price controls for the health industry, while controls on the rest of the economy had been practically eliminated in January 1973, produced predictable consequences. Cessation of controls in April 1974 was followed by a period of rapid "catch-up" wage increases.

Prices for nonlabor goods and services skyrocketed, partially as a result of the hospitals' dependence on petrochemicals and also the explosion in malpractice insurance rates. During 1974 and 1975, hospital costs for nonlabor goods and services rose more than 17 percent. Consequently, the rate of increase in hospital expenditures also returned to the 16 to 17 percent level experienced during the medicare implementation period.

The cause of the most recent round of increases is, however, vastly different from the demand-induced inflation during the early medicare years. As the following table illustrates, in 1975, nearly three-fourths of the increase in hospital costs resulted from increases in prices hospitals paid for labor, other services, and goods. In 1969, only slightly more than one-third of the increases went to paying these higher prices. The recent rise is an example of "cost push" inflation, heightened by the oil crisis and overextension of the Economic Stabilization Program (ESP), rather than the "demand pull" inflation of the 1960's generated by implementation of medicare and medicaid.

[The table follows:]

PERCENTAGE OF INCREASE IN PER DIEM HOSPITAL COST, BY FACTOR

	1969	1975
Total	100.0	100.0
Added quantity of care	65.6	26.7
Quantity of goods and services	51.3	11.0
Number of personnel	14.3	15.7
Higher prices and wages	34.4	73.3
Prices of goods and services	11.7	44.8
Average hospital wages	22.7	28.5

Mr. McMahon. It is clear, Mr. Chairman, as you look at that table on page 3 because of the very nature in hospital costs, no simple solutions are available. The increases are due primarily to four factors.

First, a portion of the increase in costs results from the rise in prices and wages in the rest of the economy which necessarily impacts on hospitals. The need to maintain competitive wage levels, particularly, has a heavy impact in a labor intensive industry such as ours.

Second, the hospitals' market basket is unlike that of any other sector in the general economy, and the costs of goods and services purchased by hospitals are more heavily weighted by those costs which are rising at a faster rate than the cost of living. For example, the average annual hospital liability insurance premium rose from $13,000 in 1970 to more than $110,000 in 1975. This represents a 1,000-percent increase in just 5 years. In Chicago during that period, according to a study conducted by the Chicago Hospital Council, hospital malpractice insurance premiums increased 1,200 percent, and it is estimated that the cost of such insurance for the hospitals surveyed is now between $40 and $43 per patient day. Although increases in costs of food and energy, two major staples in the hospital market basket, have not been as dramatic, they nevertheless have risen at a rate much higher than that of the Consumer Price Index. Food prices, for example, have risen an average of 8.4 percent per year over the past 5 years, and energy costs have risen 15.1 percent per year over that same period.

The third factor affecting hospital cost increases is the changing nature of the output of the hospital. As a result of continuing research and new technology, services provided by hospitals are constantly improving in terms of treatment methods and the expansion of capability for dealing with conditions previously untreatable or untreated. Renal dialysis, laser surgery, total blood replacement, cancer therapy, and a host of new diagnostic approaches to diseases are but a few of the many examples of the costly improvements and expansion of hospital services. From 1965 to 1975, the number of intensive care units increased by 130 percent. Further, there has been a very significant increase in the intensity of these services resulting from a variety of factors, including shortened hospital stay, increased clinical capability, defensive practice of medicine, and public demand. The American people expect these improvements in health services to be available, and their expectations intensify the use of such services and produce an increase in the costs of health care.

A fourth factor contributing to the increase in hospital costs is statutory and regulatory requirements imposed by Government. In our opinion, such requirements too often have added significantly to the cost of providing services without bringing a commensurate improvement in health care. H.R. 13267, introduced by Representative Max Baucus, which is pending before this committee, points up some of the problems of small and rural hospitals arising from the application of rigid Federal regulations. We believe it essential that, prior to the establishment of such requirements for any hospital, it be determined whether the costs of compliance with such requirements will result in commensurate benefits to patients. Further, regulations must be sufficiently flexible to recognize variations among hospitals with regard to their size, scope of services, availability of health manpower, and geographic isolation.

In addition to the above factors, in considering the increasing costs of medicare and medicaid programs, it is important to note two special elements: (1) An ever-increasing medicare population which is the result of increased aging in the population as a whole, and (2) the special impact of the recession on the needs and numbers of beneficiaries of medicaid. Moreover, Congress has increased the scope of benefits under these programs—for example, through the inclusion of the disabled under medicare, and the extension of medicare catastrophic benefits for renal dialysis and organ transplantation, to persons of all ages in need of treatment for renal failure.

If cost rises due to increases in the intensity of care, product enhancement, the hospital market basket, and the increased coverage and benefits to Federal program, beneficiaries were excluded from consideration, the increase in hospital costs would be reasonably comparable to price increases in the general economy. Yet, all too frequently, these basic factors are ignored in considerations directed at getting a handle on rising health care costs.

Hospitals are very concerned with rising costs, so is the American Hospital Association. We have in recent months expanded our services to get a handle on rising costs. We are in the process of getting out this month a series of guides on how hospitals can develop cost containment committees, to use our cost containment manual, all to the end that every hospital can make every dollar stretch as far as possible. But it is frustrating when, on the one hand, they are criticized for rising costs and on the other, they are obligated by Federal mandate to take actions which increase wealth expenditures.

CURRENT PROPOSALS TO LIMIT HOSPITAL REIMBURSEMENT

The bulge in hospital and health care costs since the end of wage and price controls coupled with severe constraints on the 1977 Federal budget, have stimulated proposals that stop just short of reinstating mandatory controls on the health industry. Among them, the President's 1977 budget proposes a 7-percent limit on increases in per diem reimbursement under medicare which would have an intolerable impact on hospitals. This proposal would not directly impact upon the factors that produce rises in hospital costs and, in fact, would not have an effect upon hospital costs specifically, but would only reduce what the Government would pay when purchasing medicare services. The problems that hospitals would face under this proposal would be worse than those experienced under the much discredited economic stabilization program.

The administration's budget proposal estimates that $730 million would be saved by the imposition of the 7-percent limit during fiscal year 1977 and that $1.9 billion would be saved during fiscal year 1978. But the proposal would not reduce the cost of hospital care in these amounts or even necessarily reduce health care expenditures. As we noted earlier, many components of hospital costs, for example, the prices which hospitals must pay for energy, malpractice insurance premiums, food, and supplies, are largely beyond the control of the institution. The so-called savings would have to be accomplished either by a shift of medicare costs to nonmedicare patients, or by reducing the level of services now being provided to patients.

Imposition of a percentage cap, with the expectation that hospitals would continue to provide the services that have been promised to beneficiaries, places these institutions in a financially untenable position and forces them to seek to defray these unmet costs through additional charges to other payors. Arbitrary ceilings on hospital prices will perpetuate the disruption that has been previously produced by wage and price controls. They will postpone the necessary confrontation with underlying factors that have increased the costs of hospital and health care.

As you know, Mr. Chairman, the First Concurrent Budget Resolution calls for a total reduction in the medicare and medicaid budget of $700 million for fiscal year 1977. The imposition of an arbitrary ceiling on Federal expenses without consideration of the costs incurred by hospitals in the provision of covered services is not an appropriate or equitable method of dealing with the problem of health care costs. We are opposed to an across-the-board cut which would adversely impact on the quality and availability of needed hospital services to program beneficiaries and which would jeopardize the financial viability of the Nation's hospitals. Government should promise the American people only what it can realistically fulfill in terms of financing and delivery of health care services.

In considering any control of the rate of increase in hospital costs, improvements in the quality and type as well as increase in the quantity of services must be addressed. We are encouraged by the congressional actions of recent years that address factors which contribute to hospital costs rather than merely limit Federal reimbursement for costs that are incurred in providing services. Congress has enacted two key measures designed to deal with those issues.

Public Law 93–641 provides for health planning and State-level certification of need. Implementation of this statute will exercise a strong control over additional capital expenditures. Such expenditures and the resultant operating costs account for an important part of the overall increase in hospital costs. The American Hospital Association strongly supports this activity.

The Medicare Amendments of 1972, Public Law 92–603, provide for the development of professional standards review organizations—PSRO's—which, coupled with institutional quality assurance programs, address the issue of quality of health care and the control of utilization of services. Hospitals on a voluntary basis have for many years supported this process, and in 1970 AHA developed a detailed methodology for institutional quality assurance programs. Further, the Joint Commission on the Accreditation of Hospitals requires quality assurance programs as part of its standards for accreditation.

Both of these laws address factors which directly affect the costs of the medicare and medicaid programs.

PROSPECTIVE REIMBURSEMENT APPROACHES

Increased attention and experimentation have been given in recent years to prospective reimbursement methods in the payment for health care services. In our view, no single method has emerged that has proved satisfactory for general application. Therefore, experimentation should continue, and before the adoption of any system, there should be adequate time for trials and validation of the method so that, if necessary, modifications may be made.

This is the premise on which we based our analysis of the hospital reimbursement provisions of H.R. 13080. There are three sections—sections 10, 11, and 12—of this bill which deal with hospital reimbursement. Section 10 proposes significant changes in the Federal reimbursement mechanisms for hospitals and we have carefully studied these changes. We believe this section, as modified by our recommendations, to be a significant improvement over the existing provisions of section 223 of Public Law 92–603 which it is intended to replace.

Any system to classify institutions for the purpose of reimbursement on a comparative basis has its difficulties, and we certainly endorse the removal, from the comparison procedure for routine per diem hospital costs, of a number of elements which are beyond the control of institutions. Clearly, any classification system should be sufficiently sophisticated to separate efficient from inefficient institutions. Our suggestions for modifications of section 10 are designed to reinforce the intent of the bill to protect the efficient ones and to motivate the others to increase their effectiveness. We offer the following suggestions to make the proposed incentive reimbursement system more effective, equitable, and workable.

First, the bill calls for "a uniform system of accounts and cost reporting—including uniform procedures for allocation of costs—for determining operating and capital costs of hospitals providing such services. * * *" Uniform cost allocation and reporting is obviously necessary to an adequate comparative system of reimbursement. However, we wish to be sure that the accounting requirements instituted under this provision would be consistent with the requirements imposed on hospitals by other private and governmental programs.

Second, an ongoing system of hospital classification is presented, utilizing bed size and type of facility as its basis. While these two variables are important, it would be necessary to evaluate the appropriateness of the specified breakdowns according to bed size and to provide adequate opportunity for exceptious review. For example, a 100-bed general hospital in a rural area will not infrequently have a more complicated case-mix and a totally different mission than a similar-sized general hospital in an urban area.

Similarly, while there is need to separate institutions by the types of services they provide, a comparative evaluation may be hampered by the small sizes of the groups which may result. Additionally, the category provided for hospitals which are primary affiliates of accredited medical schools appears extremely restrictive and, as the committee knows, not infrequently a number of hospitals may be affiliated with a single medical school.

Third, the bill, in defining routine operating costs, provides that such costs exclude four items which are, in fact, beyond the control of the administration of an institution and have in the past created difficulties in any comparative classification scheme. We suggest that an exclusion for costs related to malpractice insurance premiums be added. These costs have not only risen precipitously in recent years, but their impact has not been uniform across the country. The exclusion should cover the costs of both professional and general liability insurance, which usually are sold as a unit.

Among costs excluded from routine operating costs are "energy costs associated with heating and cooling the hospital plant." However, we strongly recommend that all energy costs be excluded for two reasons: (1) There is a significant variability in types of energy sources used by hospitals and their costs in various regions of the country; and (2) the differentiation of the costs of energy by type and use—for example, electricity, which is used for not only environmental controls, but for lighting and many diagnostic and therapeutic purposes—is very difficult, if not totally impractical.

Fourth, the bill provides that the personnel component of average per diem routine operating costs shall be adjusted through the use of a wage index based on general wage levels prevailing in the areas in which the hospitals are located.

Our concern here is the fact that this index refers to wage levels in the general economy rather than the segment of the labor force from which hospitals recruit their employees. It must be pointed out that the correlation between these wage levels is, at best, approximate because many hospital employees are highly specialized. Moreover, to the best of our knowledge, wage data of nonmetropolitan areas are not available on a periodic basis, and it is in these areas that approximately 50 percent of all hospitals are located. Therefore, a new wage index must be developed and maintained, and we believe it is essential that it be based on that segment of the labor market from which hospitals must recruit. Furthermore, although hospitals which have characteristically higher wages would be granted a 1-year reprieve, they would be subjected thereafter to controls which fail to recognize that those higher levels of costs may be fixed, for example, by virtue of prior contractual agreements, or may be maintained by State or local law, as in the case of public institutions.

Fifth, section 10 provides that:

> * * * at the end of the fiscal year a retrospective adjustment will be made in the amounts paid a hospital to reflect the lesser of the cost increase incurred by the hospital or the cost increase in prices which occurred in goods and services used. * * *

The problem with this provision is that a hospital could be told at the beginning of the year that it would be reimbursed, say $100 per patient day, for its routine services, and budget accordingly for this expected payment—but if at the end of the year the Government determines that the forecasted price increase was in error, and that the hospital should be paid $95 per patient day, the institution would incur a deficit. We do not believe that hospitals should be placed at risk in this manner which would permit a retrospective denial of reimbursement of incurred costs on the basis of an erroneous economic forecast.

We are concerned also about the specific language detailing the arithmetic to be used in arriving at the projected estimate of the average per diem routine operating costs to be applied to a given period. We are uncertain that the present language provides that the costs used in the base would be properly adjusted to take into account the fact that hospitals have varying fiscal years. A varying inflation adjustment would be needed both in the base data and in determining the projected estimate to be used for a given hospital. The estimate should vary, depending upon the date a hospital's fiscal year begins.

Sixth, the section further provides that hospitals may seek an exception for two basic reasons, one of which is an "unusual case-mix." This exception for case-mix deals with only one aspect of a difficult problem in evaluating the appropriateness of the cost level of a hospital. That problem is an assessment of the intensity and complexity of care provided by the institution. Intensity is affected, of course, by the case-mix of patients served. One of the problems faced by hospitals with case-mixes believed to require unusual levels of intensity of care is that they do not have the required data to prove their point. The bill should provide that the Secretary of HEW would make the needed data available to all hospitals within a classification group.

A second point in the provision for exceptions with which we would take issue is the omission of factors in addition to case-mix which affect intensity of care, for example, length of stay, which may also be valid grounds for exception. Hospitals with high patient turnover rates (shorter lengths of stay), usually a characteristic of more efficient operation, would be particularly hard hit since the per diem routine cost in such institutions is generally higher than in institutions with longer average stays. Increased costs for providing routine care not reflected in case-mix also occur in hospitals in which patients rarely employ private duty nurses. Public hospitals and other facilities providing care for many indigent patients must compensate for the absence of privately employed nurses through their own nursing staffs.

Further, patient mix alone does not necessarily reflect in full the complexity of service that may be provided in one institution as compared with another, although it has important cost implications. We recognize that the state of the art for determining and comparing this set of extremely important variables as they relate to costs is poorly developed. It is essential that considerable additional analysis and development of evaluative procedures and appeal mechanisms be undertaken as critical adjuncts to the reimbursement procedure to be sure that either the basic process or the exceptions approach covers all needed factors.

Seventh, the bill provides that for hospitals in Alaska and Hawaii, adjustments may be made in the per diem payment rate to reflect higher prices prevailing in those States. This is an important and appropriate provision; however, prices paid by hospitals in other regions of the country do not necessarily reflect the national average, and similar allowances should be provided for them as well.

Eighth, we are greatly concerned about the provision which would tie the incentive reimbursement formula to average per diem costs within a group of comparable institutions without provision for evaluating and altering an unwarranted, and we believe unintended, "ratchet" effect. If, as intended, the results of the incentive formula would be that each year average per diem costs would potentially be reduced, additional hospitals not previously found to have high costs would be so identified and penalized. This would be the inevitable consequence each fiscal year of cost reductions in hospitals classified in the highest category. Unless some accommodation is made to recognize this trend, the eventual result would be that high quality and complicated health services would no longer be feasible in many health care institutions. We do not believe that this is the intent of the committee and recommend that legislative language be included to insure that a review of this matter will be made every 2 years after the system is applied so that the system may be evaluated and modified accordingly.

Ninth, this bill's provisions on medicaid reimbursement to hospitals are limited to assuring that the reimbursement does not exceed amounts payable under section 10 of the bill. The bill would not apply this new method of reimbursement to medicaid. This omission would perpetuate a very serious problem for hospitals in some areas where the State seeks to obtain hospital services for medicaid patients at rates that are below cost and thereby places hospitals in financial jeopardy. We would hope that the bill could be modified to require that medicaid payments be at an equitable level.

Tenth, an exceedingly important issue not addressed in section 10 is the financial impact of charity care and bad debts on hospitals. The costs of providing services for needy patients who are not covered by any program are a very serious problem of many hospitals, and we would urge the committee to consider reimbursement provisions to support the necessary care of such patients.

Eleventh, the bill wisely provides that implementation of section 10 would occur over a period of 2 years with only one-half of the penalties and incentives applied during the third year after enactment. Many complicated aspects of this reimbursement system fundamental to its successful implementation are yet to be developed and evaluated. During the period prior to the full implementation of the proposed reimbursement system, we strongly urge a full-scale evaluation of its effectiveness by the Secretary of HEW, who should be authorized to recommend appropriate modifications to the Congress.

And now, Mr. Chairman, we have an additional, and major, change to offer to section 10. We urge that section 10 be amended to provide that where a State rate review program has been implemented, either by statute as in Maryland and Connecticut, or voluntarily as in Indiana, which applies to all purchasers of care other than medicare and medicaid, and which is designed to meet the full financial requirements of the hospitals covered by the program, then medicare and medicaid should be required to pay the rates established. State rate review programs would not apply to Federal purchasers in those States, as for example, Massachusetts and New York, where programs do not meet the requirements of covering all nonfederal purchasers of care.

Our reasons for this proposal are quite simple. If State rate review programs cover all patients except medicare and medicaid beneficiaries, and the latter pay according to a different formula, it is very likely that some hospital costs will not be met. Moreover, the application of two sets of formulas to two sets of patients may well result in one set of patients subsidizing the care of the other contrary to the long-established principle of Public Law 89–97, opposing such subsidization.

We believe that this amendment will achieve equity among all third-party payers. Moreover, it should be designed to meet the full financial requirements of health care institutions, including the costs of patient care; approved educational and research programs not otherwise financed; capital expenditures consistent with community planning decisions and approved through the planning controls provided in Public Law 93–641; and an operating margin to provide working capital, the equity base for future capital expenditures, and the undergirding of the risk of unforeseen contingencies.

We do not believe that it would be advantageous at the outset to develop an extensive or rigid set of additional specifications for State rate review programs. There should be room for adequate experimentation and validation which would provide the basis for further refinements in this area. States should be given the opportunity to decide whether to offer one system of reimbursement or more than one. We believe the provision of alternatives within a State rate review program is an appropriate area for experimentation.

The proposal we are urging will not operate as an open door to the Federal Treasury. As a matter of fact, the record of the State rate review programs described below is one of moderation of rates of increase in health care costs. For example:

First, in Maryland, the Blue Cross Association reported on May 30, 1975, that the Maryland Health Services Cost Review Commission (HSCRC) and held hospital rate increases to a level substantially lower than rate increases elsewhere in the Nation. Harold Cohen, director of the Maryland HSCRS, recently reported to a Senate health subcommittee that hospital rate increases in that State have dropped well below the national annual average since the commission's inception. The Maryland experience is especially valuable because both medicare and medicaid have recently agreed to participate in the rate review program.

Second, in Connecticut, under the legislatively established Commission on Hospital Health Care, similar comparisons can be made. John K. Kittridge, past vice president of Prudential Life, and chairman of the Council on Consumer and Professional Relations of the Health Insurance Association of America, has said that "the Connecticut experience is significant because the rate of escalation in that State similarly paralleled or slightly exceeded the nationwide experience through 1973, the year the Connecticut Legislature established the Commission on Hospital and Health Care." The following table presents the comparative experience of Connecticut and the Nation since establishment of the Commission:

HOSPITAL PRICE INCREASE

[In percent]

	Connecticut	United States
1973–74	6.1	11.8
1974–75	8.3	13.9
1975–76	9.6	14.9

These statistics reflect price increases, in percentages, for private sector patient charges. In the 3 years since the implementation of the State prospective rate review system, the increase for Connecticut hospitals has been 60 percent of the national average.

Third, in Indiana, where a voluntary program has been in effect since 1959, a study commissioned by the Social Security Administration showed for 1972 that "for short-term hospitals * * * average increase in per diem operating cost was 11.3 percent compared to the national average of 13.8 percent; the per case cost increase in Indiana was 8.6 percent compared to the national average of 11.5 percent."

Absolute dollar figures show the significant difference between average costs in Indiana hospitals for 1972 and average national costs:

	Indiana	United States
Cost per stay	$720.13	$826.16
Cost per patient day	89.95	105.09

Although these data relate to only 1 year's experience in Indiana, the rate of increase in hospital costs in that State has been consistently lower than the national rate.

The advantages of consideration of hospital costs and reimbursement at the State level was recently discussed in testimony before the House Ways and Means Committee's Oversight Subcommittee. Elmer W. Smith, an Associate Commissioner of the Social Security Administration, said that in order to be successful, prospective payment systems must include all payors. In a statement before the Senate Committee on Labor and Public Welfare Subcommittee on Health, Alice M. Rivlin, Ph. D., Director of the Congressional Budget Office, also suggested that efforts to moderate hospital costs must apply to all purchasers of care.

To sum up our arguments in support of this proposal, we believe it will provide equitable treatment for all third-party payors, avoid subsidization of one group of patients by another, and at the same time be effective in moderating increases in hospital costs. As the committee moves ahead in the development of legislation in this area, we will welcome the opportunity to pursue these details with your committee staff.

TRANSITIONAL ALLOWANCES FOR CONVERSION OF BEDS

AHA supports section 11 of the bill. However, as it is presently written, the section provides that applications for assistance would be approved only retrospectively, leaving unanswered the potential for obtaining such assistance before the conversion of beds has taken place.

We urge that an application for support under this section be reviewed and approved prospectively so that an institution which retires or converts beds in the manner outlined in its approved application can be assured of the payment upon which it will be dependent.

RETURN ON EQUITY FOR INVESTOR-OWNED FACILITIES

Section 12 would increase the rate of return on net equity allowed for purposes of Federal reimbursement to investor-owned hospitals to twice the average return on the Social Security Trust Fund. The AHA supports this provision on the principle that a suitable return on investment is necessary to insure that investors will continue to advance capital for investor-owned facilities. In addition, we recommend an adequate margin of revenues over expenses for not-for-profit institutions. We are now developing the specifics for an adequate margin, and will provide these to your committee in the near future. This margin is absolutely necessary to provide working capital, the equity base for future capital expenditures approved through the planning process and the undergirding of the risk inherent in prospective payment mechanisms. The advantage of this approach to all third-party payors, including medicare and medicaid, lies in the reduction of interest charges on money which otherwise would be borrowed at high interest rates to meet these requirements and contingencies.

CONCLUDING REMARKS

In summary, Mr. Chairman, we are fully aware of the complexities of the areas which your committee is addressing. We have reviewed some of the major factors that have contributed to the increase in hospital costs. Equitable changes can be accomplished in the hospital reimbursement system, providing they address these factors and do not place arbitrary limits on payments for services—limits which would restrict the ability of providers to deliver the promised services to Federal beneficiaries. With reference to specific legislation before the committee, we have made a series of recommendations for developing an improved hospital reimbursement system. We have appreciated the opportunity to participate at this hearing and look forward to working with the committee and its staff in the further consideration of these matters. I will be pleased to answer any questions you may have.

Mr. Rostenkowski. Thank you, Mr. McMahon. Dr. Gehrig, do you have anything to add?

Dr. Gehrig. No, sir.

Mr. Rostenkowski. Mr. McMahon, you discuss in detail in your testimony the provisions of 13080. It is my impression that that legislation will cover only routine costs and will do so only over a period of years.

The question that comes to my mind is what is to be done in the interim as hospital costs continue to rise each year?

Mr. McMahon. Mr. Chairman, as we tried to point out, the reason why hospital costs rise is, in part, because of factors beyond the control of hospitals.

Second, they rise because of the improvement in the nature of hospital services.

Section 10 of H.R. 13080, it is true, would take some time to work out. I have pointed out in my testimony that we have controls on expenditures. We are developing controls over utilization and this third factor in the increase in hospital costs is one on which there are no clear answers.

We are saying to you, Mr. Chairman, and members of the committee, that artificial attempts to do anything quickly are going to have two disadvantageous results. Either they will shift the costs because they are payment restrictions, not cost restrictions—they will either impose those costs on other third-party payors or they will restrict the ability of institutions to deliver the services Congress has promised to medicare and medicaid patients.

Mr. Rostenkowski. Mr. Corman.

Mr. Corman. Thank you, Mr. Chairman.

You suggest we continue our reimbursement demonstrations, but I understand the only institutions willing to experiment are those who feel there is no risk. Are we really getting enough cross-section to get some valid data?

Mr. McMahon. In the first place, Mr. Corman, I don't think it is exactly right to say there are few institutions at risk. Sometimes we tend to concentrate on the hospitals particularly in the Northeast quadrant of the United States which have traditionally lived under retrospective reimbursement or retrospective payment mechanisms. There are lots of hospitals across the southern part of the country and in the Southwest and West that have long been on prospective payment mechanisms, in effect, because they have had to develop a charge structure and post that charge structure and live within it until they get the approval to change that from some of the major third parties.

The thing is that when you take a country as varied as ours with different kinds of reimbursement mechanisms, it is awfully difficult to say there is one that everybody can live with starting the day after tomorrow. This is the reason we think experimentation is necessary to work out over time which ones will have the most significant impact on cost or the most significant balancing of costs on the one hand, with the ability of the institutions to render service on the other.

So, we think there is still much room for experimentation. We are going to have, if the Congress will follow our recommendations, some east coast experimentation in Maryland and Connecticut.

As I understand it, we will have some in California because they are headed in the direction of a State rate review program. You can judge those two areas along with Indiana and Wisconsin where there is another voluntary mechanism in place, to see in comparison which of those areas are doing the most and which have the best set-up.

Mr. CORMAN. Do you think we are getting a sufficient broad-based experience that we will learn something from the experiment?

Mr. McMAHON. Yes; I do.

Mr. CORMAN. There is really not much cost saving if the patient is copayor. It does not cost less if the patient pays the full bill himself, a part of the bill, or none of the bill?

Mr. McMAHON. Mr. Corman, we have not been able to identify that, but admittedly there are differences of opinion. I think the general feeling is if the copayment provision is small, it wouldn't have very much effect at all. If it is large, it will have an effect, but it may have an effect on the wrong individuals. It may have an effect on those least able to pay.

Mr. CORMAN. Maybe I did not make my question quite clear. It does not have any effect on the unit cost in the hospital. It may have an effect on how long the person uses the service, but it would not have any effect on the unit cost in the hospital, would it?

Mr. McMAHON. No, sir, unless it has a sufficient impact so that some people that might otherwise be taken care of them do not seek care. Then you have an impact on the unit cost. So many hospital costs are fixed that if you have a reduction of 2 or 3 percent in occupancy, you will probably have an increase in the cost of the patients who are remaining because of that fixed cost aspect. That goes a little beyond your question, but we must remember the fixed-cost implications of hospital care.

Mr. CORMAN. The big bulge in demand really kind of works for you as well as against you? If there is a bulge in demand in the hospitals with 100-percent occupancy, the unit costs will go down. The fact there are a lot of other people shopping for a hospital does not really have an effect on your unit cost. You do not charge what the traffic will bear because there are a lot of people out there.

Mr. McMAHON. No, sir, we have tracked that and we know there is very little change in the excess of revenues over expenditures over time.

In addressing myself to your question I am assuming that you were talking about the unit costs of production. Of course, there is another implication to this. On occasion there are bad debts on uncollectible debts, though they don't affect the unit cost of production, they may affect the cost of care to others because the production costs of hospital services that are not paid for because of the uncollectibles, then must be collected from someone else. While it wouldn't affect the unit costs, it may affect the charges to other third parties.

Mr. CORMAN. Let me see if I understand. If there is a hospital with half medicare and half not and has a 5-percent bad debt, is that charged against the other 45 percent who are nonmedicare patients?

Mr. MCMAHON. The other 45 percent because neither medicare or medicaid will reflect in their payment formulas the bad debts of nonmedicare and medicaid beneficiaries.

Mr. ROSTENKOWSKI. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

Elaborating further on what Mr. Corman said: Do you think medicare should take into consideration the bad debt ratio of a hospital?

Mr. MCMAHON. Absolutely, Mr. Duncan, because that is a cost that the hospital incurs, in effect, or a cost that it fails to recover. We have long taken the position that medicare and medicaid along with Blue Cross and the commercial carriers all ought to recognize bad debts as a cost-spreading responsibility.

Mr. DUNCAN. Actually, the failure to pay the full cost for hospital care for a medicare-medicaid beneficiary causes a shift in costs then to the nonbeneficiaries?

Mr. MCMAHON. Yes, sir.

Mr. DUNCAN. Is that a big problem?

Mr. MCMAHON. It is a huge problem, Mr. Duncan, because it is an inequity. There isn't any reason it seems to us for one group of sick people to be burdened by the costs that are incurred by another group. The costs of care ought to be spread equitably over all of the payors. Another reason why we have suggested the change to section 10 to provide that where a State has developed an all-inclusive rate mechanism, then all third-parties ought to pay those rates which are fixed. At that time, the cost containment activity has gone into place, those costs are under surveillance and medicare and medicaid would thus under any circumstances obtain the benefits of those cost-reduction measures.

Mr. DUNCAN. What effect would the new minimum wage proposal have upon hospital costs?

Mr. MCMAHON. It would vary geographically, but across the board, it would increase them. Some hospital employees in some areas of the country are paid the minimum wage now. If the minimum wage is increased in those areas, then the wages of the employees now at the minimum would have to be increased and then you have an upward movement across the board to obtain equity.

Mr. DUNCAN. For every nickel or dime increase, can you give us an idea of what it would cost? What the increase would be?

Mr. MCMAHON. Mr. Duncan, between 50 and 60 percent of hospital costs are wages. If you had 10 cents and say a 5-percent increase in the hospitals that would be affected, one must recognize in some areas of the country, the bottom wage scale is beyond the minimum, but across the area of the country you and I know best it could have a 5-percent increase in the minimum wage could have a 2- to 3-percent increase in hospital costs.

Mr. DUNCAN. I understood you to say you would like to see the Federal Government adopt the same plan that the various States have? Did I understand you correctly?

Mr. McMahon. Yes; where a State has developed a rate review program which covers all non-Federal, all third-party payors, then we think the Federal Government should accept those rates and in medicare and medicaid pay the rates thus set. That does not apply at the present time to very many States, and we are talking about equity for the hospitals in those States.

Mr. Duncan. What degree of control would you have, Mr. McMahon?

Mr. McMahon. You have the control of a State agency or a broadly based voluntary commission as in Indiana. Taking a look at every hospital, inquiries of every hospital, concerning the increase it seeks in its budgets, if the increases in rates are justified—for example, are there increased services for numbers of patients? As I have indicated in pages 16 and 17, you can see some of the ways in which those programs have kept the rate of increase in hospital costs below the average in the rest of the country.

So, the advantage is, first, it is not a meat ax approach. It looks at every institution on its own. Some institutions at any one time are going to increase their costs for any one year more than another. By reviewing on an institution by institution basis and by taking into consideration the variations, Mr. Duncan, that do exist across the country, and in what people want by way of hospital services, as opposed to the way they would use the dollars they have in other areas. Such a review provides a useful flexibility.

Mr. Duncan. Mr. Chairman, could I, at this point, enter for the record a long-range medicare-medicaid reform program that was prepared for the Tennessee delegation by the Tennessee Hospital Association.

Mr. Rostenkowski. Without objection, it is so ordered.

[The information follows:]

LONG-RANGE MEDICARE/MEDICAID REFORM: THE KEY TO HOSPITAL COST CONTAINMENT

(An analysis, with recommendations, prepared for the Tennessee Delegation of the United States Congress, July, 1976, by The Tennessee Hospital Association)

The Federal Government's ambivalent attitude toward health care has been brought into sharp focus through the initial application of the new Congressional budgetary process.

In mid-May, the House and Senate approved a conference agreement on the first concurrent budget resolution for Fiscal Year 1977.

Spending for all Federal health programs was set at $37.9 billion, with $21.4 billion allocated for Medicare expenditures and $9.3 billion for Medicaid. This constitutes a $500 million cut in Medicare expenditures and a $300 million cut in Medicaid.

The ambivalence is found in the fact that this $500 million recommended cut in Medicare expenditures was accompanied by a recommended $200 million increase in benefits. Thus, in microcosm, we find the now traditional situation wherein the Federal Government is attracted to the idea of extending health care benefits but repulsed by the necessity of paying the costs of those benefits.

In September, The Congress will adopt its second and "binding" budget resolution which will more accurately reflect expected revenues and expenditures for FY 1977.

In arriving at its final budget, The Congress will be forced to make some difficult decisions.

Presuming the existing consensus prevails that Federal health spending must be reduced or, at the least, curtailed, one of three courses of action may be taken:

1. The cost-effectiveness of the Medicare and Medicaid programs can be

improved by enacting new legislation aimed at reforming the methods of financing, payment and administration, and by adequately funding existing programs aimed at improving their long-range cost-effectiveness.

2. Reforms can be initiated, along with arbitrary limitations on reimbursement to providers of health care services and a reduction in benefits.

3. Arbitrary limits may be placed upon reimbursement while increasing benefits, maintaining the existing level of benefits, or reducing benefits.

Hearings on these matters are now being conducted by various bodies of The Congress. Regardless of their outcome, it is clear that The Congress will not undertake any further major expansion of health care benefits to the American people—such as envisioned by various national health insurance provisions—until basic issues involving the Medicare and Medicaid programs are resolved through fundamental policy decisions—a procedure which has strongly and consistantly advocated by The Tennessee Hospital Association for a number of years.

As the Tennessee Delegation to the United States Congress participates in this policy-making process and prepares itself to cast crucial votes in committees and on the floor of the Senate and House, we hope they are mindful that the debate involves far more than the future status of Medicare and Medicaid.

In essence, The Congress is debating the validity of the Federal Government priority of assuring equal access to quality health care at a reasonable cost as established by Section 2(a)(1) of Public Law 93–641.

The Tennessee Hospital Association is fully committed to the achievement of that priority since it is almost identical with the purpose of the Association as established in its Bylaws.

Therefore, because the debate concerning the future of Medicare and Medicaid indirectly involves achievement of this crucial priority, the Association, as the organization representing a billion-dollar segment of the health industry, feels a strong obligation to share with the Tennessee Congressional Delegation its perception of existing problems, an assessment of approaches being considered by The Congress in solving the problems and recommendations as to what course of action would be most appropriate.

THE CONSEQUENCES OF ARBITRARY PAYMENT LIMITATIONS

Currently there are three proposals before The Congress which would simplistically attempt to control federal health expenditures through the expedient of arbitrary limits on the amounts to be reimbursed to providers for the care of program beneficiaries. These are:

The administration's proposal to limit the annual increase in per diem charges to seven percent for hospitals.

Rep. Dan Rostenkowski's proposal to impose a 9.5 to 10 percent limit on increases in costs, coupled with a plan to phase-in a prospective reimbursement system over a three to four year period to replace the cap.

The Congress' budget resolution which arbitrarily reduces the Medicare-Medicaid budget by $800 million which, in the absence of a reduction in benefits, would translate into lower reimbursement rates.

The Tennessee Hospital Association shall utilize all of its resources to oppose any such action, whether or not it is combined with any needed reform package, for the following reasons:

1. Arbitrary caps only address the problem of total cash outlay by the Federal Government and impede the process of affecting reforms needed to achieve the national health priority.

2. Such action ignores the economic needs of hospitals in carrying out their obligations to all patients and the communities they serve.

3. It widens the gap between the legislative promise of the programs and what they actually provide beneficiaries, causing further disillusionment with the health care system which further impedes its ability to deal with very serious shortcomings in the delivery system.

4. The failure to pay full cost for the care of Medicare and Medicaid beneficiaries causes a shift in cost to non-beneficiaries.

The Association stresses that these reasons are not based upon speculation but are based upon documented fact.

Most of these proposals for arbitrary caps are based upon the spurious assumption that the Medicare-Medicaid programs operate on a "cost-plus" reimbursement system which results in payments which are in excess of the individual institution's full economic needs.

This assumption is as dangerous as it is erroneous. The fact is that Medicare and Medicaid payments are already substantially below the hospitals' cost.

This fact has been fully documented in four different studies of the Tennessee community hospital system conducted by the Association and other organizations during 1975 and 1976. Summations of these studies are found in the Appendix.

In addition to bringing the results of these studies to the attention of Tennessee's Congressional Delegation, the Association continues to interpret their significance to the general public, selected Governmental agencies and committees, news media representatives and other centers of influence concerned with health care.

These efforts to keep various publics informed about the true ramification of federal programs and policies shall continue unabated.

COST CONTAINMENT THROUGH BASIC REFORM

This Association is cognizant of the necessity to contain rising national health expenditures. We agree Medicare and Medicaid reimbursement procedures require basic reform. We remain, however, adamant in our previous conviction that these basic reforms must be of the kind that will give support to the development of a total cost-effective health care system which will serve all categories of patients equally.

Any basic reforms which deliberately or inadvertently, only benefit beneficiaries of federal programs must, in our opinion, be strongly opposed as being discriminatory and counterproductive to achievement of the national health priority.

It remains the opinion of this Association that two programs now being implemented are supportive of the achievement of a cost-effective health system under which all patients would benefit. These are:

The Professional Standards Review provisions of Public Law 92–603, the Social Security Amendments of 1972.

The National Health Planning and Resources Development Act of 1974 (Public Law 93–641).

Both programs are now being implemented nationwide and both are victims of the traditional pattern of federal government ambivalence.

Although both laws were, in the wisdom of The Congress, conceived and enacted as programs designed to bring about fundamental and long-range reforms in the health delivery system with the ultimate goal of maintaining quality while assuring improved cost-effectiveness, they have been fiscally deprived.

The opinion of some is that the programs have been deliberately underfunded in an effort to discredit the private health sector. The theory here is that since these programs depend largely upon the cooperation and support of the providers of health care services, if they fail, blame may be placed upon the private health sector. This could then be used as per se evidence that the private health sector is unwilling to bring about basic reform and that the only alternative open is a direct or indirect federal take-over of the health system.

In opposition to this rather paranoiac view is the attitude that the programs are being underfunded through ignorance. The theory here is that the programs and their intent are just not fully understood, thus causing funding to be cut and diverted to other areas.

Regardless of which, if either view is correct, the fact remains that neither program is being given an adequate opportunity to prove effectiveness.

The PSRO program has already been subjected to close Congressional scrutiny and challenged to prove its cost-effectiveness even though it is not fully operational.

The new health planning law is now in its very early stages of implementation. The kingpin to this entire elaborate planning law is the local Health Systems Agency (HSA). The HSAs were to have been funded on the basis of an allocation amounting to approximately 45 cents per capita in the area covered by the individual HSA.

Initial funding levels for those now turning operational on a conditional basis have been set at approximately 19 to 22 cents per capital.

Thus, while assigned sweeping and exceedingly far-reaching responsibility by The Congress, they have not been provided the resources needed to carry out those responsibilities.

Thus, both programs have been subjected to the traditional Federal ambivalence which finds it attracted to the concept but repulsed by the necessity of paying full program costs.

The THA believes that both programs can prove effective in helping The Congress determine priorities in health spending.

The PSRO program is a system which monitors quality and, through medical care evaluation studies, areas of health care most in need of improvement.

The health planning law is designed to help correct deficiencies in the allocation and distribution of health care facilities and services. It provides a mechanism through which monies earmarked for improvement of the delivery system (as opposed to monies expanded for services) can be allocated with the greatest efficiency.

In combination, these programs offer The Congress the potential of being able to reduce expenditures for services and make allocations to strengthen the delivery system on a selective and systematic basis which simultaneously allows long-range reduction in expenditures and improvement in cost-effectiveness.

In the absence of these programs, The Congress lacks the capability of making rational and effective decisions and will continue to find its programs to be counterproductive—as it specifies in Section 2 of Public Law 83–641.

In addition to these programs, The Congress now has before it other programs (bills) which the THA believes holds major potential to bring about needed and long-range reforms which would also facilitate the creation of a total cost-effective health system.

The first series of proposals deal with regulatory reform.

To date, Congressional concern with rising costs is directly measurable by its output of amendments to existing laws and new laws which are stimulating an exponential growth in rules, regulations and guidelines.

Many are duplicative and conflicting. An example is the Bureau of Health Insurance (BHI) tightened Utilization Review Regulations which almost exactly duplicate new requirements mandated by the Bureau of Quality Assurance (BQA) pursuant to the new PSRO law.

The power struggle between the BHI and BQA has placed the nation's hospital system in the position of having to comply with two duplicative programs at an expense to the taxpayer which is incalculable. The PSRO–UR debacle stands as a national disgrace and a monument to the inefficiency of the bureaucracy.

The cost to health institutions of complying with bureaucratic and regulatory paperwork has never been adequately documented. Efforts by the THA to do so in Tennessee resulted in cost estimates so ludicrous they are unbelievable (but as yet unchallenged by the U.S. Department of Health, Education and Welfare as presented by the THA to the President's Commission on Federal Paperwork).

The House Rules Committee is continuing to review the Administrative Rulemaking Reform Act of 1976 (H.R. 12048) while the Senate Judiciary Committee's Subcommittee on Administrative Practice and Procedure is examining a number of bills that would reform the federal regulatory process.

The THA strongly supports the intent of all these bills, especially to the extent that they would provide The Congress an opportunity to review proposed rules and regulations to assure they are consistent with the intent of The Congress in enacting enabling legislation and to the extent that they would provide more time for evaluation and input between the time of their proposal and implementation.

By far the most far-reaching and complex proposal now before The Congress is Sen. Herman E. Talmadge's bill, "The Medicare/Medicaid Administrative and Reimbursement Reform Act" (S. 3205), which we are pleased to note has been introduced in the House (H.R. 13080) by Rep. John Duncan.

It is the initial consensus of the Association, following a preliminary examination of the bill, that it, more than any other alternative now before The Congress, best reflects the concerns of the Tennessee hospital industry.

It is the feeling of the THA that this bill would attempt to contain costs without the need of indiscriminately slashing payments to providers and would eliminate the necessity of imposing arbitrary controls which would ultimately be counterproductive.

The THA, at the present time, is not ready to provide the Tennessee Congressional delegation a detailed analysis of this highly complex bill. It does, however, strongly advocate early and serious consideration of its provisions.

RECOMMENDATIONS OF THE TENNESSEE HOSPITAL ASSOCIATION

It is the consensus of the THA that arbitrary "caps", or other limitations on payments for services rendered beneficiaries to federal health programs, will be counterproductive and discriminatory to non-beneficiaries and lead to further circumvention of the Congressional intent of enabling legislation.

We share the concern of The Congress about escalating costs of health care and agree that methods must be found by which the health care system can be made more cost-effective.

Accordingly, the THA recommends to the Tennessee delegation to the U.S. Congress that it:

Vigorously oppose any attempt to further reduce payments to providers for services rendered to beneficiaries of federal health programs.

Utilize their influence to assure that the Professional Standards Review Program and the National Health Planning and Resources Development program are funded at full authorized levels.

Provide strong support for early enactment of regulatory reform measures which would assure that rules and regulations are consistent with Congressional intent and which would assure that those affected by proposed regulations would have at lesat 60 days to consider and respond to the proposed regulations and rules before implementation.

Consider support for concepts incorporated in Sen. Talmadge's bill as alternatives to arbitrary spending limitations.

The four studies contained in this appendix were performed during 1975 and 1976 from data acquired during 1974 and 1975.

These studies show that the Medicare and Medicaid programs do not result in compensation which is adequate to meet the hospitals' expense. On the average, during 1974 and 1975 total Medicare reimbursement only paid 87 percent of the hospitals' per diem expense of providing the care.

This inequity, caused by discriminatory Federal price-fixing regulations, forces the hospitals to inflate charges to non-Medicare/Medicaid patients. During 1975, for example, patients covered by Blue Cross paid nearly 113 percent of daily expense.

Even with this discriminatory pricing system, caused by federal price-fixing regulations, aggregate Tennessee community hospital revenue from providing service to patients has not met the aggregate total operating expense in any year since 1969.

TENNESSEE HOSPITAL INCOME STUDY [1]

The data below is based upon a study of 27,376 cases admitted to 46 Tennessee community hospitals during March, 1975. The cases accounted for 192,207 days of care and resulted in charges totaling $23,398,558. Each case was followed for 90 days from the date of discharge. The following chart was constructed from the data and other sources and was not shown in the final study:

Category	Charged	Paid	Expense	Net loss/ gain
All	$121.73	$96.93	$102.25	−$5.32
Blue Cross	126.92	115.52	102.25	+13.27
Insurance	126.09	103.90	102.25	+1.65
Medicare	112.73	88.97	102.25	−13.28
Medicaid	118.02	88.85	102.25	−13.40
Self-pay	128.96	46.67	102.25	−55.58

Findings

Medicare/Medicaid total per diem reimbursement, including collectibles and year-end adjustments (estimated), only amounted to 87 percent of the average hospital per diem expense.

Blue Cross per diem reimbursement amounted to 112.9 percent of the hospitals' average per diem expense.

Charges not recovered by the 46 hospitals (all sources) totaled $5,776,600 for the month or 24.7 percent of total charges.

Medicare accounted for 38.67 percent of all uncollected charges.

---

[1] Sponsored by the Tennessee Hospital Association and Tennessee Chapter, Hospital Financial Management Association. Released in April 1976 through the THA.

INPATIENT INCOME ANALYSIS, PER PATIENT-DAY, AVERAGE FOR 132 COMMUNITY HOSPITALS, 1974

Data for the following analysis was obtained from the annual survey of hospitals and the U.S. Department of Health, Education, and Welfare. The Medicare income reflects total Federal reimbursement to Tennessee hospitals for the fiscal year ending June 30, 1974 as reported by DHEW plus a 20 percent increase to reflect year-end adjustments, supplemental payments and collectibles.

Per patient-day expense: 5,760,538 days at $512,242,160	$88. 91
Per patient-day income:	
Medicare: 1,954,962 at $150,567,600	77. 02
Medicaid: 213,751 days at $16,573,743	77. 54
Nonpayors: 126,732 days at $0	0
All others: 3,512,805 days at $332,919,877	94. 77
Average: 5,760,538 at $500,061,220	86. 80
Net income per patient-day	(2. 11)

Findings

Total per diem reimbursement for the care of Medicare/Medicaid patients averaged 87 percent of the hospitals' cost (not charges).

Payments by all other paying patients averaged 106.5 percent of the cost of providing the day of care.

The average per diem reimbursement for all patients was only 87.6 percent of the hospitals' cost.

74 HOSPITAL SURVEY OF MEDICAID AND INDIGENT CARE, NOVEMBER, 1975[1]

	November 1975 (actual)	12 mo (projected)
Medicaid days of care	22, 547	270, 564
Days paid or approved	16, 783	201, 396
Unpaid days, medicaid	5, 764	69, 168
Value of unpaid days	$615, 667, 14	$7. 388, 005
Additional unreimbursed days	6, 431	76, 092
Value of additional unreimbursed days	$738, 440. 59	$8, 861, 287
Total value, all unreimbursed days	$1, 354, 107. 73	$16, 249, 292

[1] Tennessee Hospital Association Medicaid Survey, November, 1975.

Findings

During the study period the hospitals provided Medicaid beneficiaries 22,547 days of care but were only paid for 16,783 days.

The value of the uncompensated Medicaid care was $615,667 which, projected into twelve months, totaled $7,388,005.

The hospital provided 6,341 additional days of care to non-Medicaid patients which went unreimbursed worth $738,440.59.

Total unreimbursed days of care during the months totaled 12,105 days worth $1,354,107.73.

Projected over twelve months, the 74 hospitals provided 145,260 days worth of unreimbursed care worth $16,249,292.

COMPARISON OF SERVICES UTILIZED TO NET REVENUE BY CATEGORY OF PATIENT: SIXTEEN HOSPITAL STUDY

The following chart is taken from an independent study of "Services Offered and Operating Characteristics of 16 Not-For-Profit Hospitals In the State of Tennessee," Performed by Ernest & Ernest. The study utilized data from 1974 fiscal year and was released in July, 1975. The 16 hospitals which participated in the study provide 39 percent of the state's community hospital beds and handle approximately 50 percent of all community hospital admissions.

SOURCES OF PAYMENTS FISCAL YEAR ENDING 1974[1]

Payor	Percent of services utilized	Percent of net revenue
Title V (crippled children)	.03	0.03
Title VIII (medicare)	29.52	27.29
Title XIX (medicaid)	1.66	1.53
Total	31.21	28.85
Blue Crcss	19.06	18.68
Other commercials	37.58	41.75
Self-pay	9.65	10.72
Charity	2.50	0
Total	100.00	100.00

[1] From "A Study of Services Offered and Operating Characteristics of 16 Not-For-Profit Hospitals in the State of Tennessee," July 1975, Ernst & Ernst.

Patients whose care is subsidized by the Federal government utilize 31.21 percent of a hospital's services but only account for 28.85 percent of the net revenue.

Mr. ROSTENKOWSKI. Mr. Cotter?

Mr. COTTER. You cited some of the reasons for increases in hospital costs, such things as increase in malpractice insurance premiums, catchup after wage and price controls, and other factors. In my estimation, these are all valid reasons, but these increases in hospital costs are nothing new. They go back beyond these problems that you have encountered during the last 2, 3, 4 years.

Can you relate to me what the average increase in hospital costs were, say, from the mid-fifties? Wasn't the average similar to what we are experiencing today?

Mr. MCMAHON. No; it was lower then for several reasons. In the first place, the inflationary tendencies in the late fifties in the rest of the economy were not as high as they are today, and, second, we did not have in motion some of the things then that we have today.

I would mention, first, the tremendous activity in the research area in part assisted by the activities of the National Institutes of Health and the research efforts of the private companies that are hospital suppliers.

In the second place, we had not made the decision we made during the 1960's to markedly increase the flow of health manpower, particularly in the production of physicians. When the Congress decided in the 1960's to increase the number of physicians from an entering class, let us say, of 9,000 students, to 15,000 and now we are on our way to 18,000—no thought apparently was given to the fact that when those students graduated from medical school there would be a tremendous increase in hospital costs because all of these students take their postgraduate training in a hospital setting.

This involves costs or stipends and salaries of interns as well as teaching physicians to supervise their work.

So, back in the 1950's, the rate of increase in hospital costs was lower. As we got into the 1960's particularly with medicare and medicaid, 1964, 1965, 1966, after medicaid, 1965, 1966, 1967, we experienced hospital cost increases very similar to those today.

As my testimony indicates, though, it was a different mix. It was not the same mix of inflation or increase in the cost of hospital inputs, as the economists call it. It was a smaller amount for that and a more substantial amount for an improvement in service.

Right now, we are feeling the effects of cost-push inflation because of the 16 percent that we are seeing now or saw last year. A substantial amount of that increase just went to staying even because of malpractice insurance premiums, the energy costs, and so on, though there was a chunk of improvement in products and the educational costs that are growing out of these increased numbers of graduating physicians that we now have in our postgraduate medical education programs.

Mr. COTTER. But you cite during the 1960's the increase per annum is similar to what we are experiencing today.

Mr. McMAHON. It was somewhat lower than that in the early part of the 1960's, but in the late part of the 1960's we had medicare and medicaid. We had experience in the private health insurance world of an increasing emphasis and sale of catastrophic coverage, and we had then the research activities and the educational activities coming on.

I don't remember the figures specifically, but certainly it was lower, 10 or 9 percent in the early parts of the 1960's. It has, since the war ended, since World War II—it has tended to be substantially ahead of the cost of living because, if we look at hospital costs, we are talking about the improvement of product. We tend in the United States to equate two dissimilar things. We talk about the cost of living on the one hand, which does its best to reflect an increase in the prices of similar products, and we talk about hospital costs which are more than prices. It includes the improvement of product over time.

When we look at a cost of living increase of 6 or 7 percent and a hospital cost change of 16 and 17 percent, we are not talking about the same thing. If we were to talk about prices, we are probably looking, when we look at 6 or 7 percent change in the cost of living, we are talking more about 10 to 11 percent in changes in prices, and then another 3 or 4 percent for product improvement—more people cared for, and so on.

Mr. COTTER. From your experience or the experience of the hospitals in Maryland and Connecticut, can they live with this ceiling which has been established by the various commissions?

Mr. McMAHON. We are not sure if they can or not. I have talked to hospitals in both States. Some of them seem to think that they can manage well. Others are having difficulties.

But the advantage to it, even if they have grave difficulties, at least everybody knows where the responsibility rests. If by the squeezes on prices and rates, it gets to where the hospital cannot provide the services, not only the hospitals, but the people and the patients in those two States will know where the buck stops.

My argument about two separate formulas means so often, as we have learned to see it in the hospital field, each of the formulamakers blames the others. Medicare and medicaid say the whole problem lies in the rates fixed elsewhere. The people paying the other rates say it is medicare and medicaid's lack of willingness to pay the rates we do.

As I indicated in the testimony, both Mr. Smith and Dr. Rivlen have that in mind when they say that adequate cost containment means that whatever is done ought to apply across-the-board to all third-party payors.

Mr. COTTER. If this is the case, to follow your argument, why not put a ceiling on hospitals similar to what they have done in Maryland or Connecticut and let the hospitals live within it?

Mr. McMAHON. It is not a ceiling. It deals with every institution on its own. If you mean why not have the Federal Government do that, my response would be that people vary from State to State in the level of hospital care, medical care, that they want. One single formula from Washington, we do not think, would be as useful as attention to this problem at the State level.

Mr. COTTER. You take Connecticut, particularly in the Hartford area, you have hospitals which provide practically every type of service known to mankind. If they can live within this 9.6, it would seem as though other hospitals throughout the country which don't have any higher costs, should be able to live with it, too.

You also have other hospitals in other parts of the country which don't have high malpractice insurance rates, which don't have high energy costs, which should be able to comply without any difficulty.

Mr. McMAHON. I would say two things in response: The first, the 9.6 is an aggregate target. Where an institution finds it needs more than that, it has an opportunity to argue its case. Where it needs less, they don't get it.

Mr. COTTER. There has been a situation where the Commission has been overruled on it.

Mr. McMAHON. Yes.

Mr. COTTER. To what degree?

Mr. McMAHON. That, I don't know. We are still tracking that. I have asked our staff to take a look and understand better what the situation is.

The other aspect about it—there was another aspect to your question, and that is if the hospitals in Connecticut can live with 9.6 with the kind of sophistication that they have in the Hartford area, why can't hospitals in the rest of the country?

To some extent, of course, a percentage is against a base and if you have a lower base, that 9.6 wouldn't generate as much of an increase in dollar flow.

Anytime you use an across-the-board percentage like that, it tends to freeze things like they are and would tend to prevent hospitals elsewhere, where the people want it and are willing to pay for it, to develop themselves to the point that those sophisticated hospitals in Hartford have reached.

Mr. ROSTENKOWSKI. Mr. Burleson?

Mr. BURLESON. I am not sure of the parameters of your discussion Mr. Chairman, but I wonder who might discuss Public Law 93-641—is that the correct reference to regional planning?

Mr. McMAHON. 93-641.

Mr. BURLESON. Will someone discuss that in the course of our hearings?

Mr. ROSTENKOWSKI. The staff informs me that we will not have any witnesses to testify exclusively on that particular act today.

Mr. BURLESON. I will pass for the present time, Mr. Chairman. Thank you.

Mr. ROSTENKOWSKI. Mr. McMahon, the AHA has endorsed Mr. Ullman's NHI bill, H.R. 1 and its particular method of reimbursement for hospitals. There was another bill introduced in the last Congress by Mr. Mills that would have required 50 percent of the incentive payment made to a hospital under a prospective system of reimbursement be passed down to the hospital managerial personnel, the people who in practice are most responsible for the efficiencies achieved. Is this possible? Do you think that such a system could be workable?

Mr. McMahon. Mr. Chairman, we don't think it ought to be mandated, particularly in the not-for-profit hospital, there is some difficulty that might take legislative sanction with passing on any savings to employees. If it were authorized, we think it would be a useful experiment. The difficulty is in some cases those savings may or may not grow out of the activities of employees—for example, a change in occupancy, a change in patient mix may bring about a lower cost because, then the fixed costs are spread over a larger number of patients.

Therefore, a requirement that that be done, by passing management and in effect substituting legislation for managerial judgment, we think would not be appropriate, but certainly the authorization to do so, to provide encouragement to see what we can do with incentivizing employees using this as a permissive method using employees, we think, would be an excellent idea.

Mr. Rostenkowski. If this is not feasible, what would not-for-profit institutions do with their incentive payments which by definition would be in excess of cost.

Mr. McMahon. They would do the same thing as we argued for in a plus factor of operating revenues over expenditures. In times of inflation, costs are not adequate to deal with working capital. A payment solely of cost is not adequate to develop the equity which hospitals, after they have gotten the approval through the planning process of capital expenditures, can borrow money against.

For example, I had something to do with an institution which recently had a major expansion approved by the planning process, and it was necessary to raise from philanthropy as well as from depreciation and other dollar flows in that hospital about a third of the cost of a project. That then provided adequate security to the lenders who provided the institution with two-thirds of the money.

Finally, any kind of incentive payment that would go into a hospital reserve protects it against the vagueries of any prospective payment mechanisms. For example, in any prospective mechanism, you must make some estimates of occupancy and mix of patients so you know what the dollar flow will be from the patients served.

Sometimes, those estimates will go awry if occupancy falls. You will not always get all the money to meet the costs incurred. We are saying both the risk factor and incentive payment retention factor are extremely useful to protect the hospital against what may happen in the future. If one says this can provide money that could be used inappropriately for expansion of facilities that are not really needed, we point to Public Law 93–641 and say no longer would this be possible.

Mr. Rostenkowski. I think we are all concerned with what fuels the health-cost cycle, Mr. McMahon, and it just concerns me that if we simply use the surpluses to finance additional capital acquisitions, that would further fuel the health-cost cycle.

Mr. McMahon. There is no question about that, Mr. Chairman. That is why I made reference to the planning law. Under the planning law, hospitals will not be able to expend that money for any kind of capital expenditure. That capital expenditure will have to be approved through the planning process.

Mr. Rostenkowski. Do you think the planning process will be able to withstand the pressures to build attractive but nonessential facilities?

Mr. McMahon. I think it is certainly in the democratic process, Mr. Chairman. It is the best we have. I think it will be. I think it provides a forum, a table if you like, around which the providers of care on the one hand, and the community being served, the would-be patients on the other hand, can decide the level of care they want, and balance that off against what they are willing to pay for. We think, and we have long been supporters in the American Hospital Association of such planning. It did not work without the regulatory power of certificate of need. We think this is worth watching. We are convinced the one controllable in the hospital area are the capital expenditures. We think that the planning process is not going to bring capital expansion to a halt, certainly because the people out there want their hospitals and doctors to have the advantages and benefits of the latest treatment methodology, the latest equipment, and so on.

Mr. Rostenkowski. Thank you very much.

Mr. Pettengill, Mr. White, welcome to the committee, gentlemen. If you will identify yourselves, you may proceed in your testimony.

STATEMENT OF DANIEL W. PETTENGILL, VICE PRESIDENT, AETNA LIFE & CASUALTY, HEALTH INSURANCE ASSOCIATION OF AMERICA; ACCOMPANIED BY WILLIAM C. WHITE, VICE PRESIDENT, PRUDENTIAL INSURANCE CO.

Mr. Pettengill. Thank you, Mr. Chairman. I am Daniel W. Pettengill, vice president of Aetna Life & Casualty. With me is William C. White, Jr., vice president, the Prudential Insurance Co., of America.

We appear on behalf of the Health Insurance Association of America, whose 318 member companies are responsible for over 85 percent of the health insurance written by private insurance companies in the United States. We appreciate this opportunity to comment on the topics the subcommittee has under consideration today and shall discuss them in the order listed in the announcement of this hearing.

TOPIC 1

The factors contributing to the continuing rise in the costs of hospital care have been well-documented in recent years. They include our inflationary economy, a factor that is not under the control of either the hospitals or the third-party payers but is directly influenced by the actions of the Federal Government itself. We applaud the efforts of this Congress to contain inflationary pressures, but a much greater and more effective effort is needed.

A second factor is the continued development of high-cost technology. We all want the best care possible, and we don't want to stifle medical progress, but the total cost of health care is beginning to compete seriously with other essential needs, such as defense, education, energy, environment, housing, and transportation. Thus, there needs to be a joint public-private effort to evaluate the cost/benefit effectiveness of expensive new equipment and techniques and to assure efficient use of those that are found to be effective.

As part of this effort, the medical technology studies unit of the Office of Technology Assessment needs to be strengthened. Also, the health systems agencies established pursuant to Public Law 93–641 should assure that expensive new equipment is initially limited to those institutions already having the capability of fully exploiting its uses and hence of assuring its cost/benefit effectiveness. Furthermore, both public and private health care insurance plans should consider not providing benefits for new technology until it has proven of value. Then when a new technique has proven itself, consideration needs to be given as to whether benefits for some obsolete technique should be ceased.

A third factor is the continued use of hospital confinement when the patient could be as safely and effectively treated on an ambulatory basis. This occurs notably with certain types of surgery and much diagnostic testing. To combat this factor, health care plans need not only to cover the cost of ambulatory care but also to exclude benefits for hospital room and board charges in such instances. Such action, combined with an extension of effective PSRO review to all patients, should reduce the cost of necessary care and eliminate some wholly unnecessary care as well.

The foregoing presupposes that suitable alternative ambulatory care is available, where as such is often not the case. Thus, hospitals need to be encouraged to develop, in conjunction with other organizations where appropriate, comprehensive ambulatory care programs. Equally important, the hospital's medical staff needs to be educated to use such programs in lieu of inpatient confinement when it is medically appropriate to do so. Finally, the public needs to realize that, as unnecessary days of hospital confinement are eliminated, the base over which the hospital can spread its fixed overhead costs becomes smaller and hence its board and room charges must be increased. The truly sick patient will incur a larger bill, but the total hospital bill of the Nation will be reduced.

A fourth factor is the excess beds and other equipment plus attendant staff that exist in many areas of the Nation. We need not only to avoid future excesses but also to eliminate some of those that already exist. Human nature being what it is, no hospital will voluntarily close down all or part of its operations. Therefore, studies need to be made to determine when it would be less costly for the public to have a specified sum of money paid to a health care institution to close down some or all of its services rather than to continue year after year financing the overhead of such unused or rarely used services.

When only some services of a hospital are so closed down, the specified sum paid the hospital for doing so should be the basis of a valid charge to all patients and their third-party payers, including the Federal Government. When an entire hospital is closed down, the money might well be taken from the grant funds normally available to HSA's to improve the health care delivery system; otherwise, the use of some other tax revenues will have to be authorized.

A fifth factor is the increasing amount of defensive medicine practiced to minimize the likelihood of a successful malpractice suit. While retraining, and in some cases outright removal, of imcompetent physicians should reduce the number of valid malpractice suits, it would not remove the presumably costly practice of defensive medicine. This is so because our judicial system now concentrates less on whether the physician or hospital was really guilty of negligence and more on the condition of the patient. If the patient's condition has not improved significantly or has gotten worse even though he received the very best of medical care, the jury tends to award the patient damages, and does so in ever larger amounts. Thus, no reduction in the practice of defensive medicine is likely until our present system of tort law is reformed.

A sixth, and perhaps the most important factor, is the woeful lack of sane health habits on the part of so many Americans. We are a Nation of free people who resist regimentation and dictatorship. So, we are willing to pay the price of some self-indulgence. The difficult question is when and how should one person's freedom be restricted in order to prevent a complete loss of freedom for others. Speeding or driving under the influence of alcohol or drugs are examples of freedoms of the few that must be more effectively restricted for the benefit of the many. In addition, both Government and the private sector ought to try harder to find more effective ways of educating our people to reduce the number and severity of their health care problems by taking better care of their own minds and bodies. That portion of this educational effort that deals with how best to take care of oneself following an essential hospital confinement would seem to be a proper responsibility of the hospital and hence a valid cost that all third-party payers should recognize.

One would also have to classify the method of reimbursement used by medicare and certain other third-party payers as a factor contributing indirectly to rising hospital costs because it contains no incentives for economy or efficiency. I refer to reimbursement on the basis of audited costs. There is widespread agreement that this method of reimbursement has outlived its usefulness and needs to be replaced.

TOPIC 2

Turning now to the results of the most recent analyses of experience under prospective reimbursement approaches, we find that voluntary approaches have generally been unsuccessful. Furthermore, prospective rates that apply to only certain classes of patients are likewise ineffective for the public as a whole because the hospital is left with an escape mechanism through which it can pass on to its other parties those costs not covered by the prospective rates.

For example, on January 1, 1970, New York State adopted a system of prospectively approved rates that is applicable to just medicaid and Blue Cross plans. Hospitals are permitted to pass excess costs on to their remaining private-sector patients. That the New York hospitals have actually done so is evidenced by the fact that the direct charge for a semiprivate in New York State has increased 51.8 percent between 1971 and 1975, while that for the United States as a whole increased only 43.2 percent.

Connecticut enacted prospective rate legislation in 1973, effective in 1974, that applies to all private-sector patients. The Connecticut system has succeeded in keeping price increases significantly below the average for the United States as a whole as is evidenced by the data in table I.

TABLE I.—PERCENTAGE INCREASE IN HOSPITAL CHARGES

Years	Connecticut	United States
1974 over 1975	6.1	11.8
1975 over 1974	8.3	13.9

However, if the Connecticut system is to continue to be successful, we believe medicare and medicaid must agree to pay the same prospectively approved rates as the private sector. In addition, the Commission on Hospitals and Health Care, which is the rate regulatory agency, needs representation from third-party payers and more adequate financing for its staff.

TOPIC 3

We believe the role of State rate regulation in a revised medicare hospital reimbursement system is an essential one as long as the licensing of hospitals and the granting of certificates of need are handled at the State level. We appreciate the concern of the Federal Government as to the effectiveness of State rate regulation. We believe this potential problem is best handled by having HEW empowered to review the general level of rates granted by each State for each category of health care institution. When, after competent review and a public hearing, the Secretary of HEW found the general level of rates approved by a State to be clearly excessive, the Secretary should be required to reduce the amount of health care funds otherwise payable to that State by the Federal Government to compensate for the excess cost to the Federal Government of accepting the excessive charges approved by the State. The State would not be permitted to recoup this reduction by cutting its own payments to hospitals. Hence, this approach would not penalize the patients or the institutions and should result in the State's taking corrective action in the future to be more cost conscious in approving rates. With such a safeguard, we believe it is both appropriate and essential that medicare and medicaid pay the approved charges of each health care institution.

TOPIC 4

Alternative approaches to setting prospective rates not only should be experimented with but also will probably always be necessary because of inherent differences among various health care institutions. The cost of complying with and administering prospective rate review must be clearly less than the hoped-for savings in benefit dollars to be produced by this method of reimbursement.

Specifically, we are opposed to any retroactive adjustments. The extent to which a health care institution's total expenditures for approved services for a given fiscal year exceed the sum of the total income produced by the rates which the State approved for that year and such other actual income as was assumed to be credited against expenses for purposes of determining the approved rates should be separated into two parts. One part of the excess would represent increased expenditures clearly beyond the control of both the lay and medical staffs of the institution, such as electricity, food, and fuel. The other part would represent all other increases. The amount of the first part should automatically be a valid cost for determining the rates for the ensuing fiscal year. The second part should be a loss to the institution that it will have to make up by more efficient operation in the future.

While we are opposed to retroactive adjustments, we do recommend that, when certain significant increases in specified uncontrollable costs occur, the health care institution should be allowed to increase its charges for the balance of the fiscal year by an amount sufficient to compensate for the increased cost. For example, if electricity were 10 percent of an institution's costs and, 2 months after the fiscal year began, the State authorized a 30-percent increase in the charge for electricity, then the health care institution should be allowed a 3-percent increase in its rates for the balance of that fiscal year.

Uniform cost reporting for any given category of health care institution is desirable. However, the various categories must be established with due regard for whether or not a particular uniform cost reporting is fair and meaningful for all the institutions which will fall in that category. The same cost reporting for a 50-bed hospital in a rural community would not be appropriate for a 500-bed teaching hospital in a big city.

While uniform methods of cost allocation are theoretically desirable, it is highly questionable whether the regimentation and expense involved is worth the alleged advantage of the resulting consistency. We believe that management should be required to use cost allocation methods that are reasonable and internally consistent but not necessarily uniform.

Whatever approach is used to establish prospective rates, we believe there must be financial incentives for the hospital not only to be economical but also to establish cost-saving programs such as same-day surgery, preadmission testing for elective surgery, et cetera. No system will last long if all or most of the savings the institution effects must be used to reduce its rates for the ensuing fiscal year. We also believe that bonus payments to rank and file hospital employees as well as hospital management should be encouraged when a hospital makes a net savings through its own efforts. Admittedly, windfall savings, as should occur when uncontrollable costs drop, should be applied to reduce the rates for the following fiscal year.

TOPIC 5

We question the feasibility and desirability of providing to hospitals a choice among more than one reimbursement methodology. It is logical that if a rate regulation system is to be equitable it must be applied uniformly to all hospitals in a given category. This is not to say that there should not be experimentation with various methods of determining prospective rates. Indeed, we regret that HEW has not done more in the way of experimenting to find effective approaches to prospective rate setting. We are given to understand that one major constraint under which HEW labors is that no experiment may be undertaken which would in any way increase the cost of the medicare program even though the increase be only temporary and the potential for a net, long-term reduction significant. We urge Congress to remove this constraint. As to the conditions under which it might be desirable to recognize and reimburse in accordance with a State ratesetting program that meets specified criteria, we believe these have been set forth in our answers to topics 2, 3, and 4.

TOPIC 6

As we have already indicated, there is no question but that special provisions relating to the control of capital expenditures must be included in any system of establishing prospective rates. For health care institutions, an appropriate relationship to the health planning process established by Public Law 93–641 should assure this. It is our understanding that Public Law 93–641 requires each State, desiring to receive funds under the Public Health Service Act, to enact certificate of need legislation by September 30, 1979. Unfortunately, such laws usually apply to hospitals but not to physicians' offices. These certificate of need laws should apply to both; otherwise, some expensive equipment or service can be installed or instituted in a physician's office next door to a hospital which has been duly and validly denied the equipment or service. The computerized tomography scanner is a case in point. Another deficiency of Public Law 93–641 is the lack of a requirement that existing facilities be decertified when they are no longer needed.

TOPIC 7

We concur that the issues related to the administrative implementation of a prospective reimbursement system need careful consideration. We have endeavored to address some of them in our discussion of topic 4. Because it takes time for a State rate review commission to build an adequate, competent staff, we urge that implementation of the system be phased by category of health care institution. We also recommend that the initial system be reasonably simple, with sophistication being added when time permits and experience warrants.

TOPIC 8

Our comments on legislation introduced in this Congress to reform medicare hospital reimbursement, specifically S. 3205 (Talmadge) and its House counterpart, H.R. 13080 (Duncan of Tennessee) are as follows and apply to sections 10 and 11.

Section 10.—Improved methods for determining reasonable cost of services provided by hospitals—if hospitals are to be classified by size and type, as this section 10 requires, we recommend that they also be classified by the geographic location of the hospital because this is an important determinant of cost differentials.

We are concerned that, if the prospective method of reimbursement is based upon an average per diem routine operating cost, as this section 10 requires, there may be a tendency to have quality of care rank well below the cost considerations. We believe there must be a reasonable balance between cost and quality and hence recommend that provision also be made for a system of reviewing the quality of services provided, preferably in terms of outcomes.

We suggest that routine operating costs should be defined more clearly. In particular, wages should be included but should not be subject to a wage index factor as provided in subsection (3) (E). Routine operating costs should then be limited, for reimbursement purposes, by category of hospital (including geographic area) to some appropriate figure such as, for each category, the mean plus one standard deviation.

Finally, whatever method is used to determine prospective rates, we believe it essential that the resulting rates be applied to all patients.

Section 11.—Inclusion in reasonable cost of hospital services an allowance for retirement or conversion of underutilized facilities—we take exception to the provision that one of the five members of the Hospital Transitional Allowance Board be "a representative of the largest private nonprofit third-party payer for hospital services in the Nation." Other third-party payers should be represented on the board. With this exception, we agree with the intent of this section.

There will continue to be problems, however, in the financing of the retirement or conversion of underutilized facilities since the Government's share of such allowance will be limited to a proportion based on the usage of such facilities by patients covered under titles XVIII and XIX of the Social Security Act. This will leave a substantial amount of financing necessary from other sources, and problems in finding such sources may defeat the purpose of this provision. We, therefore, suggest consideration of an amendment to Public Law 93–641 to provide specific funds to health systems agencies to assist in filling this gap in financing for the retirement or conversion of underutilized health facilities.

TOPIC 9

With respect to considerations for and against imposing, prior to the full implementation of a prospective reimbursement system, a ceiling on total hospital cost increases recognized as reasonable by medicare, we believe there is only one important consideration; namely, that to impose an arbitrary limit on what Medicare will pay will either increase the out-of-pocket expenditures of an already overburdened medicare patient or increase most unfairly the costs of the sick nonmedicare patient, or do both. As severe as the medicare financing problem is, it does not warrant such grossly unjust action.

This concludes our testimony. We shall be pleased to try to answer any questions the subcommittee may have with respect to it.

Mr. ROSTENKOWSKI. Although the focus of this hearing is on incentive reimbursement systems for hospitals, do you believe it would be possible to develop incentive payment systems for the intermediaries and carriers that would increase program efficiency?

Mr. PETTENGILL. I do, sir, and I hope your committee will consider this.

Mr. ROSTENKOWSKI. Mr. Corman?

Mr. CORMAN. Do private insurance companies have a capacity to control hospital costs?

Mr. PETTENGILL. That is a very valid question, sir. My answer is individually no. Collectively, as representatives on advisory councils to State hospital cost commissions, I believe we can have a very effective input.

Mr. CORMAN. Could you spell out the last part of your answer a little bit?

Mr. PETTENGILL. We do have a viewpoint which is basically that of the educated consumer, because we see literally hundreds of thousands of claims every single day. We see wherein hospital charges are not appropriately representative of what we believe their expenses to be. We see variations between hospitals. It seems to us that this is a piece of intelligence that we could bring to the State regulatory agency that would be helpful to it.

Mr. CORMAN. You have indicated that if you had a dollar incentive to help control costs that you could be helpful in trying to get a handle on medicare costs. I wonder what we would be buying from you for the dollars we would be giving you. I take it that would be the monitoring of overcharging?

Mr. PETTENGILL. I was not only referring to the monitoring of overcharging. I was referring to our entire administrative operation as either intermediaries or carriers under the medicare program. There are other areas besides monitoring costs where I think, with a reasonable return on our investment, we could be helpful. If I may say so, sir, we are being asked under medicare at the present time to work entirely on the basis of costs, and those are costs as determined by the Federal Government, that is, specifically by the Bureau of Health Insurance. It frequently happens and I know from painful experience that there are differences of opinion between the Bureau and myself as to what was a reasonable cost. It is one of those—heads, the Government wins, tails, the carrier loses propositions.

Mr. CORMAN. IRS uses that system, too.

Mr. PETTENGILL. Consequently, we feel a carrier or intermediary should be merit rated. If they are doing an outstanding job, then there should be some financial incentive. It does not have to be a whale of a lot, but it has to be meaningful by the same token. If we are going to invest in significant amounts of electronics and manpower, there should be some return on investment.

Mr. CORMAN. Thank you.

Mr. ROSTENKOWSKI. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

What kind of incentives did you have in mind when you said you favor incentives?

Mr. PETTENGILL. As I just said, I believe the Bureau of Health Insurance should merit rate each of the carriers and intermediaries. There would be some quantitative standards such as timeliness of payments and so on. There would also have to be judgmental factors. This is not something that can be measured entirely in quantitative terms. Frankly, it is no different than what a businessman does with respect to his chief lieutenants. He sets up goals for the year, performance standards against which he is going to measure results and at the end of the year he makes a subjective judgment that they have done an average job in which case they deserve their normal pay or that they have done an outstanding job in which case they deserve additional compensation.

If the intermediary is doing a substandard job, that intermediary should be placed on probation immediately. It should be given a period of time to correct its functions and if it does not do so, its contract should be terminated.

Mr. DUNCAN. Would you be concerned with the overreaction of some Federal bureaucrat or agency in putting the hospital on probation?

Mr. PETTENGILL. Since I am proposing this for intermediaries and carriers, I have to be concerned because I am one of them, but I think it is a system that is required.

Mr. ROSTENKOWSKI. Mr. Cotter?

Mr. COTTER. Thank you very much, Mr. Chairman.

I am very pleased to welcome you here. Mr. Pettengill is from my home State and his testimony in the past has been most helpful and informative.

I do have one question. You mentioned if the Connecticut Health Commission is to be successful, the private and public sector must pay the same.

Mr. PETTENGILL. To the extent there is some bad debt and there is a modest amount under medicare and a substantial amount under medicaid, which these two programs do not pay, the hospitals have no alternative but to take those bad debts and pass them on to the private sector.

In Connecticut, this is done among the private pay patients but I think it is grossly unfair for Government to do this type of indirect taxation of the private patient. All patients should be paying the same charges.

Mr. COTTER. Thank you very much.

Mr. ROSTENKOWSKI. Mr. Burleson?

Mr. BURLESON. Thank you, Mr. Chairman.

Mr. Pettengill has opened the question which I referred to earlier when Mr. McMahon was testifying and that is Public Law 93-641. It does have a relation, of course, to costs and capital investments over the long range, particularly. That is true, is it not?

Mr. PETTENGILL. That is right.

Mr. BURLESON. Although the planning is composed of local people such as hospital administrators, drawing from the private sector, the Governor of the State determining the areas—in other words, in theory they are supposed to have quite a bit of autonomy.

Mr. PETTENGILL. Hopefully so.

Mr. BURLESON. There is some fine print that says with the approval of the Secretary of HEW in quite a few places. That concerns me.

Recognizing the fact that there are a lot of small hospitals, they are not expected to do brain surgery and they are not likely to do heart transplants. But there is a concern on the part of a lot of small hospitals which I know about. They have a concern they may be engulfed by the centers. Do you think they are justified in that anxiety?

Mr. PETTENGILL. One is always conscious of the fact that the large may swallow the small. This was why we hoped that by having the health systems agencies operate on a regional basis we could avoid that very dilemma.

I do feel personally that there need to be centers where you concentrate your very expensive techniques and technology. Right at the moment, for example, the computerized tomography—I think it would be most inappropriate to put that in a 50-bed hospital. It needs to be in a highly specialized hospital where there is the staff of physicians and technicians who can, as I indicated in my testimony, carry out the investigation as to how best to use computerized tomography. At some point in time, we will know what is a reasonable charge for this service. We will know, more importantly what are the reasonable criteria for using the service and not using the service. At that point, we will be able to determine the extent to which such a piece of equipment should be placed in smaller hospitals as well as the big tertiary centers.

How far down computerized tomography should go, I don't think you or I could tell at this point in time.

There is some indication that it would probably never get down to the 50-bed hospital. This is not to say, however, that the 50-bed hospital is not an essential part of our health care delivery system, particularly for smaller communities which are some distance from the big urban centers.

So I am thoroughly sympathetic with you and I believe the health service agencies under Public Law 93–641 have to be very careful that adequate ambulatory care and a reasonable degree of hospital care is available in their particular regions.

But I think they also have to recognize that small hospitals will have to be coordinated with tertiary centers for some of the more expensive and very elaborate equipment.

Mr. Burleson. Some place in your statement you indicated that assistance or encouragement should not be given to certain new technology and equipment and to the elimination of that equipment which has become useless as applied to the technology. I assume the whole thing would be true of the entire plan of the hospital itself. That is a little difficult for me to imagine, when a small town has voted bonds and built their hospital and then have services transferred to a larger center.

As I said, on the other hand, I can't imagine that a physician is going to be doing brain surgery.

Of course, everybody wants a dialysis machine, and they want new equipment, and many of them want exotic equipment, I assume.

This is a vital part of any community, the psychological effect of transferring patients at a distance away from their local environment is very serious, it seems to me. They certainly don't want to be relegated to a first aid station.

These are things that a lot of communities and a lot of people which I know about are very concerned.

I don't know how you limit what these local organizations can do, but in some instances, they are dominated by the larger interests. They are having some discussions within those organizations. But when such rules and regulations need the approval of the Secretary, it is a bit upsetting. I have talked to Mr. McMahon and other hospital associations and doctors on this subject. It will be a lot better to try to get some limitations some place than to wait and try to undo decisions once made. Once these things become ensconced in practice to try to undo things, it is a lot easier to prevent it from being done before it is accomplished.

Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Crane will inquire.

Mr. Crane. Thank you, Mr. Chairman.

On page 5 of your testimony, you talk about the Connecticut plan for controlling costs. You indicate in the first paragraph under topic 2 that a hospital left with an escape mechanism through which it can pass on other costs not covered by prospective rates is not a functioning system—it is functioning, but not in terms of trying to contain costs. Then you cite the New York figures and the Connecticut figures. I understand that this truly exists.

On the other hand, if you were to deny the voluntary mechanism for passing those costs on to a hospital, obviously it is going to run into the red. I am curious what was done in Connecticut. You indicate medicare-medicaid benefits must be adjusted to costs. We heard in Tennessee recently their costs was 31 percent, but their reimbursement was only 28 percent for medicare patients. If you cut out that mechanism for passing on the costs, what are the hospitals to do?

Mr. Pettengill. I thought I made it clear that, at present, Connecticut does not include medicare or medicaid. We are hoping improvements will be made there where everybody will be covered.

At the moment, the regulatory agency in Connecticut does permit the hospitals to take their losses under medicare and medicaid into account as a valid expense for purposes of determining the rates they will charge to their private patients.

The point I was making is that whereas this permits the hospitals to survive because they get those moneys, it is grossly unfair to the private patients. It is a form of indirect taxation.

Mr. Crane. Double taxation.

Mr. Pettengill. That is one of the things we want corrected now.

It should also be appreciated that in Connecticut the hospital commission is looking at the budget of each individual institution and the rates of each individual institution. Whereas, yes, it does have a goal of, say, limiting increases to *x* percent, that is the overall goal; it does recognize that some hospitals will get more and some get less. So it is not a blanket figure such that all hospitals would be limited to, say, 7 percent. It may have that as an overgoal for the State, but it is looking at each institution. Some get more and some get less.

Mr. Crane. It seems to me once you attempt to try to establish some form of uniformity of hospital costs, it seems to me you are locking in a mediocrity of care that you will have differences in the quality of care from one hospital to another.

For example, if you were to put limitations on staff as a means of cost control, and today there are variations, there is the very real risk and those are arbitrary external Government-made decisions, first the overall locking mediocrity into the system and second, it strikes me there are vital decisions made in running any business that Government seems less understanding of than the people who are attempting to survive in the private sector.

Mr. **Pettengill.** This is why I made such a strong plea that those State cost commissions have either on them or as an advisory council to them, real knowledgeable people from the hospital field and from the third-party field who could bring that very type of intelligence and who would point out, "Yes, this particular hospital is living within your ceiling, Mr. Commissioner, but it does not do a good job."

I also indicated we were worried that, in applying this type of control, one may look too much at the cost and not enough at the quality and the need for balance between the two.

Mr. **Crane.** Thank you, sir.

Mr. **Rostenkowski.** Thank you, gentlemen. For the convenience of the witnesses, the Chair would like to announce it is the intention of the Chair to work until 12 or 12:15, whichever the bells permit us to. That would take us through No. 7 on the list, the National Association of Insurance Commissioners. We would then return at 1:45. The first witness would be the State of Maryland Health Service Cost Review Commission.

Mr. Bromberg and Mr. Bradley.

STATEMENT OF MICHAEL D. BROMBERG, DIRECTOR, NATIONAL OFFICES, FEDERATION OF AMERICAN HOSPITALS; ACCOMPANIED BY JOHN A. BRADLEY, PRESIDENT

Mr. **Bromberg.** Mr. Chairman, I am Michael Bromberg, director, national offices, Federation of American Hospitals.

On behalf of the members of the Federation of American Hospitals, the national trade association of investor-owned hospitals, we would like to thank the subcommittee for this opportunity to present our recommendations on revising the medicare hospital reimbursement system, as well as our views on the rising cost of hospital care.

Accompanying me is John A. Bradley, president of our organization and vice president and division director of the western division of American Medicorp, Inc.

The federation represents 1,051 investor-owned hospitals with 111,000 beds, encompassing small rural hospitals as well as large urban and suburban medical centers. These were all built or acquired with private capital, thus saving billions of dollars in public funds.

This subcommittee—indeed, all of Congress—is justifiably concerned about the costs of underwriting a Federal health budget which amounted to $38 billion in fiscal year 1976, with the major share allocated to payment for services to medicare-medicaid program beneficiaries. Congress has attempted to come to grips with the budgetary problems of providing care for the Nation's poor and elderly for over a year now. Several diverse proposals have been suggested, ranging from the imposition of arbitrary cost ceilings, the establishment of a pricing policy for institutional reimbursement, and the innovative performance-based reimbursement proposal introduced by Congressman Duncan of Tennessee, H.R. 13080, the House counterpart of S. 3205, sponsored by Senator Talmadge. This proposal, as you are aware, seeks to address the issue of rising costs through the development of a target rate system with built-in incentives for efficiency.

When medicare and medicaid were first enacted 10 years ago, and until quite recently, Congress perceived its role to be one of dispenser of a package of increasing health benefits.

The picture has changed markedly, however. The major factors in this change of emphasis are an increased demand for services coupled with decreasing governmental financial resources. Congress now appears to see its role as one of cost containment. Since the Government has become the largest single purchaser of health care, the marketplace has become increasingly artificial as Government control over both the supply and demand intensifies. The key questions which emerge are:

1. How do we assure the continued supply of quality health care at a reasonable cost in the face of escalating demands?
2. How should health providers be held accountable?
3. What role should the Government assume in determining the future of the health industry and the way it operates?

Institutional providers have long been aware of and concerned about the rising cost of providing care. We are anxious to do all that we can to alleviate the situation.

The first step is one of informing both Members of Congress and the public-at-large about our side of the cost crunch. A public opinion poll conducted for the Federation early this year by Mr. Lou Harris showed an alarming lack of public understanding of hospitals in general and the hospital economy in particular. Hospitals have obviously failed to communicate to the public the valid reasons behind cost and charge increases. Simple economics dictate that hospital costs cannot be regulated when hospital suppliers and wages are not regulated.

RISING HOSPITALS COSTS

The hospital industry has been hit with severe inflationary pressures for the past 10 years. Those pressures have included: (1) Catch-up wages in a labor-intensive industry in the late 1960's and early 1970's; (2) a second period of catch-up wages following the termination of wage and price controls in April 1974; (3) increased demand for services following the enactment of the medicare and medicaid programs; (4) a recent escalation of prices for the goods and services purchased by hospitals, particularly in the energy and malpractice insurance areas; (5) a rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive new equipment are centered in the hospital; (6) periodic increases in the Federal minimum wage; (7) higher construction costs due to increasing wage levels of construction workers and inflated material costs for hospital modernization and expansion programs; (8) the increased costs of borrowing capital; (9) decreasing lengths of hospital stays causing increased intensity of per diem services; (10) increased costs of meeting life safety code requirements; and (11) the medicare-medicaid retrospective cost reimbursement formula which has failed to meet its fair share of the total financial requirements of hospital, thereby forcing institutions to shift additional costs to private patients.

These inflationary factors have hit an industry described by the President's Council on Wage and Price Stability staff as one in which the economic rewards for efficiency and cost-reducing innovation that are characteristic of our economic system seem to be lacking. We agree with that description and urge this subcommittee to consider several legislative amendments to the medicare program designed to bring about a more competitive hospital industry in which there are meaningful economic rewards for efficiency.

The alternative is to give up on the private sector, to regulate hospitals as public utilities, and to control health care inflation by placing arbitrary ceilings on expenditures for patient care and Government rationing of medical advances and technology. We reject that alternative as economically unsound, socially unacceptable, and morally wrong.

The economics of public utility regulation in other industries has been based on the existence of monopolies unlike the health field and utility rate setting has tended to protect inefficiencies without stopping inflation.

The social policy of Congress in health care has been to assure access to quality care for those without the financial means to obtain it—not to place barriers in their path.

The moral issues implicit in any plan to impose a dollar limit on technological change in a life saving effort are staggering.

In attempting to cope with the dilemma of Federal budget restraints and increasing health care costs, there are essentially five basic options.

The first would be to reduce benefits to program recipients. As the chairman noted in his remarks inserted in the Congressional Record of June 24, such cutbacks would be unacceptable, with little chance of passage.

A second option would be to raise the regressive payroll taxes in order to finance increased program costs.

A third option is that of imposing a ceiling on payments made to providers of services. Once again, the chairman rejected this alternative, correctly predicting that such a move would be resisted by providers. Arbitrary caps on Federal reimbursement would represent an attempt to maintain the status quo for the Federal budget and program recipients, at the expense of the providers and private patients.

A fourth—and in our opinion, the most acceptable alternative—would be to develop and implement prospective rate systems that incorporate incentives for efficiency. As the chairman noted in the press release issued in connection with this hearing, former Secretary of HEW, Casper Weinberger stated:

> I firmly believe that the faulty design of Medicare and Medicaid is the principal culprit responsible for * * * inflation in health care costs. (With) The guaranteed Government payment of health care costs in virtually any amount submitted by the provider, and with normal market factors absent in the health care area, inflation was bound to happen, and it did.

Target rates should be used for providers in order to inject much needed competition in the health industry, as well as to determine the rate of Government payment prospectively. Efficient providers should be rewarded.

A fifth and final option would be to permit those hospitals with costs above target rates to charge patients the difference between the federally reimbursed amount and actual costs. Hospitals would still have an incentive to keep costs within the reimbursable amount as long as competition was provided via a prospective rate mechanism, because patients in the higher-cost institutions would be more likely to shop around for hospitals that would impose no surcharge.

PERFORMANCE-BASED REIMBURSEMENT

We realize that much of the impetus for reform of medicare-medicaid stems from increasing congressional insistence that these programs operate in a manner that is as cost efficient as possible. Replacement of the current highly inflationary system of retrospective reimbursement with a competitive system of prospective payment would be our primary recommendation for reforming institutional reimbursement.

The Federation of American Hospitals has long favored increased experimentation with prospective payments for hospital services based on negotiated rates or target rates established by a formula. Our association favors a major overhaul of the medicare-medicaid reimbursement system for institutional providers; however, we also believe that experimentation on a national basis involving several prospective payment method is necessary to determine appropriate long-range systems. As you know, such experimentation is authorized under section 222 of Public Law 92–603. However, we have been disappointed with the Department's very cautious and limited use of that authority.

We generally support the determination of a target rate for routine operating costs as outlined in section 10 of H.R. 13080, sponsored by Congressman Duncan of Tennessee as the House counterpart of S. 3205 sponsored by Senator Talmadge, but have several recommendations to make.

We endorse the general approach of section 10, which includes economic rewards for efficiency. By establishing a target based on average routine costs, the proposal seeks to inject competition among similar facilities. This is a more promising approach than the arbitrary cost ceiling advocated by some of the public utility type rate regulations proposed by others. Inflexible caps would force a reduction in quality while utility type regulation protects inefficiencies by removing all competition.

We recommend that the incentive features of section 10 be broadened to provide for provider retention of savings of up to 7.5 percent of the first $100 of a routine cost target and up to 5 percent of any excess. This would place even greater emphasis on efficiency by reducing the reward for high cost institutions compared to lower cost facilities. At the same time, the suggested revision would prevent windfall profits. A sliding scale for incentive payment is more equitable because it would make the dollar rewards uniform for all hospitals.

The restrictions on reimbursement for those hospitals with routine costs more than 20 percent above the group average should be more flexible. The exception procedure should assure that no institution is penalized for costs beyond its control. Inefficiency should be penalized but unforeseen or uncontrollable events, such as physician strikes or extraordinary increases in malpractice insurance premiums, should be recognized as justifiable causes for cost increases.

Where the restrictions on reimbursement are imposed, the facility should be allowed to charge the program beneficiary for the difference between the reimbursement ceiling and its actual costs. This is now authorized by section 223 for Public Law 92–603; however, that provision would be repealed by H.R. 13080 once section 10 becomes operational.

That type of limited surcharge is quite different from coinsurance because it would be limited to a small number of hospitals and, therefore, a small percentage of program beneficiaries. In addition, the beneficiaries would, in many instances, be able to select another facility where costs do not exceed the ceiling. This would add another element of competition by encouraging patients to consider taking a more active role in selecting a hospital. This would be possible where their physician has privileges in more than one hospital as well as in situations where the hospital is the point of entry for the patient.

We also recommend the following modifications to the definition of routine costs and the exception procedure:

Malpractice insurance costs should be excluded from routine operating costs in the determination of an average per diem for each category of hospitals. The costs of this insurance can vary tremendously from institution to institution within the same category depending on geographic location. Since this factor is beyond the control of the hospital, it should not be penalized by a target rate that doesn't take into account such cost variation.

In addition, there should be an exemption for new hospitals built with required planning approval to recognize the high startup costs as well as higher debt services of a new facility or wing. This exemption is needed because of initially low occupancy rates that push up the average per diem costs of new facilities making it unfair to expect those hospitals to compete with already established facilities. We recommend that new facilities be exempt from the target rate for their first full 3 fiscal years.

For similar reasons, we suggest an exception for sudden and uncontrollable drops in occupancy in an established facility. The economic stabilization program provided such an exception for reductions in occupancy of more than 5 percent.

Another concern is that recognition needs to be given to differences in treatment modality for psychiatric facilities. The legislation should require the Secretary to take into account the treatment modality of psychiatric hospitals and give recognition to the variation in personnel needs demanded by the different programs. State and other public institutions should be separate categories from private institutions, due to differences in scope of services.

Further, there is a need to stress that even within the nonpublic sector, the specialty hospital category, such as psychiatric, needs to take into account type of programs. For example, a psychiatric hospital that has extensive shock treatment modality will have a very different pattern of personnel requirements than a psychiatric facility that has programs which have milieu therapy treatment. Yet these are all accepted and recognized treatment modalities for mental health care.

There are two other difficulties that we foresee in the implementation of this portion of the bill. First, in establishing average per diem routine operating costs, is would appear that costs are to be determined on a historical basis with no provision made for adjustment for inflation purposes during the ensuing year. Thus, depending on the fiscal year of the hospital, these figures could be almost 2 years in arrears by the close of the hospital's projected or budgeted year. We recommend, therefore, that an actual hospital cost inflation factor be built into the bill for that period.

We urge the subcommittee to recommend a hardship exception for other unforeseen and uncontrollable events which cause significant cost increases.

The concept of phasing-in new systems is laudable; however, in this instance we would urge a faster period for implementing section 10. We believe this can be done by requiring a uniform reporting system instead of a uniform accounting system. This should save at least 1 full year in implementing the new payment system. We are concerned about the fairness and costs of imposing a uniform accounting system on a universe of hospitals which vary so in scope of services, size, and sophistication in accounting departments. The benefits of such a system may well be outweighed by the added costs and administrative problems.

PROSPECTIVE RATES

We are very encouraged to note that the trend in congressional thinking leans toward the replacement of the current system of retrospective cost reimbursement with some form or forms of prospective rates. Such a step is absolutely essential if costs are to be contained in a positive way. Prospective rate systems would inject vitally needed competition into the delivery of services; efficiency would be emphasized and rewarded and would hopefully represent a cooperative partnership among Government, providers, and third-party payers. In contrast, the imposition of an arbitrary cost ceiling would only constitute a stopgap measure that in no way represents a reform of the reimbursement system.

Unfortunately, despite the authority granted under section 222 of Public Law 92-603, experiments in the area of prospective reimbursement have been woefully inadequate to date. In testimony presented last May before Congressman Vanik's Oversight Subcommittee, representatives from the Social Security Administration acknowledged that it would be several more years before sufficient data could be collected from the limited number of prospective rate experiments to evaluate with any degree of confidence and reliability the cost benefit effectiveness of such experiments. I hope you agree that we do not have the luxury of several more years in which to merely collect data, while continuing to inflate federally funded programs through the use of retrospective cost reimbursement. It is imperative that the Secretary be directed to engage in an intensive program of experimentation with several prospective rate methods in order to determine appropriate long-range systems.

We believe that the performance-based reimbursement system outlined in H.R. 13080 and S. 3205 represents a major step in making medicare and medicaid more cost efficient. However, it is essentially not a system of prospective rates. We believe that if payments are to be closely related to actual costs, they should be calculated on a predetermined basis. Therefore, although we favor the implementation of the target rate scheme proposed in H.R. 13080 and S. 3205, we recommend that the Secretary be directed to engage in an intensive program of experimentation along prospective lines. Experimentation on a basis involving several prospective rate methods is necessary to determine appropriate long-range systems.

It is important to understand that because medicare has not paid its fair share of institutional costs for providing services to program beneficiaries, health facilities have been forced to increase charges to nongovernment patients. The inflationary impact of medicare has been felt throughout the health field. By changing the payment system to a predetermined rate, we can begin to reduce the annual inflation rate, but the medicare program must first acknowledge its obligation to pay a fair rate for services rendered. There will, therefore, be no Federal budgetary savings in the initial periods of experimentation with prospective rates. There should, however, be an immediate impact on inflation rates in charges to nongovernment patients as well as long-range cost containment for the medicare program.

An approach which we favor would be one in which the Secretary would consider and approve or disapprove a number of prospective rate systems developed by providers, third party payers and other interested parties subject to Federal guidelines. At least three or more of these payment methods should be made available to hospitals, which would then make an annual selection.

When the Secretary determines that the number of hospitals choosing a particular payment method is not adequate enough to provide a sound base for evaluating that method, then the Secretary would withdraw it and allow the electing hospitals to select another method within 30 days.

Any prospective rate method authorized by the Secretary should include at least these basic provisions:

1. Financial incentives for efficiency of hospital operations equal to the potential difference between the prospective rate and the actual rate;

2. Medicare and medicaid should pay their fair share of the total financial requirements to avoid cross-subsidization of those costs by private patients; and

3. Substantial participation by hospitals in each prospective rate method.

In addition, any approved payment methods must take into account the hospital's total costs of operation and approved capital expenditures, including the costs of financing approved capital facility or services projects.

Finally, all payment methods must include provision for a return on investment for for-profit hospitals, with the Secretary determining annually a reasonable rate after considering rates of return on investment of comparable risk.

The concept of a predetermined rate for specific treatments on a per diem or per admission basis by diagnosis is one example of the type of prospective rate system we believe should be developed and tested. Other examples include a negotiated rate with a negotiated inflation rate for the second and subsequent years of the experiment; a negotiated discount from billed charges with a negotiated inflation rate for subsequent years; a budget review process limited to facilities whose rates exceed a percentile of group charges or costs; and payment of usual billed charges in return for an agreement by the facility to freeze charges to all patients for a specified period of time.

One final note on the classification system as proposed in the bill. As long as we are only concerned with routine operating costs as defined, classifying hospitals merely by size and type is sufficient. However, looking ahead to the time when the average target rate includes ancillary services, the classification system should then be revised to include such factors as geographic location, patient mix, and the age of the facility, in order to more accurately reflect the differences among facilities within the various categories. The target rate should also be determined on a per stay rather then a per diem basis.

RATE OF RETURN

In previous testimony before this subcommittee (most recently on September 19, 1975) we urged that the medicare law be amended to create a mechanism for the annual determination of a reasonable rate of return on investment. Once again we would like to emphasize that the medicare rate of return should be equal to investments of comparable risk in other industries.

An adequate rate of return is necessary for a number of reasons, most importantly to: (1) protect the hospital's financial integrity and maintain its credit; (2) to reward investors at a level commensurate with the risk assumed in making their investment; and (3) to attrack new capital for maintenance and needed expansion.

In no other industry are income taxes not recognized as an operating expense for purposes of cost based reimbursement or rate of return. By eliminating taxes from the list of reimbursable costs, the Department of HEW has made the return on equity for investor-owned hospitals approximately 10 percent on a pre-tax basis or an after-tax return of approximately 5 percent. This may be compared to the average of after-tax return on equity for all industry in the United States of 14 percent in the service industry and an after-tax return of 12 percent for public utilities.

Investor-owned hospitals must make a fair return on investment in order to be viable, and if the Federal Government refuses to pay its fair share, this increases the return needed from the private patients in order to make the overall return acceptable. This is, in effect, an indirect subsidy to the Federal Government at the expense of private patients needing hospitalization. Such cross-subsidization represents not only a direct violation of the medicare law, but is a major cause of inflation in the private sector of the health industry.

Only last month, in a case filed in the U.S. District Court for the District of Columbia, *Humana of South Carolina, Inc.* v. *Matthews*, Civil Action No. 75–0302, the court ruled that the Secretary of HEW must establish new guidelines for the determination of an appropriate rate of return on equity capital for investor-owned hospitals participating in the medicare program. Humana contended that the current formula of one and one-half times the trust fund yield does not reimburse the reasonable cost of providing services insofar as a return on equity capital is such a cost and therefore. hospitals are forced to raise the charges of private paying patients. The court held that such cross-subsidization directly violates 42 U.S.C. S. 1395x (v) (1) (A), the law governing the medicare program. The court directed the Secretary of HEW to make a detailed study of the various factors affecting the economics of the proprietary hospital industry in order to enable the Secretary to determine the actual level of return needed to provide a reasonable return on equity and avoid cross-subsidization.

The issue of reasonable and just rates of return has been addressed in a number of other important court cases, all of which we have mentioned in prior testimony before the subcommittee.

We see three possible approaches to amending the medicare law to improve the current rate of return on investment:

1. Provide for an annual determination by the Secretary of a return equal to rates of return on investments in industries of comparable risk;
2. Recognize income taxes as an allowable cost of doing business, reimbursable under title XVIII;
3. Increase the current formula to at least three times the trust fund yield.

It would cost more than $6 billion in public funds to replace the beds built by investor-owned hospitals. If these hospitals are allowed to earn a fair return on investment enough to encourage further investment, they will furnish a considerable portion of the future money needed for new hospital construction thereby freeing public funds for other uses.

STATE RATE REGULATIONS

The chairman has invited comments on the desirability of State rate regulation in a revised system of institutional reimbursement under medicare. We have commented on the role of State rate control many times in the past, voicing our vigorous opposition to granting States such sweeping powers. Since the medicare program is financial entirely through a Federal trust fund, there is absolutely no justification for entrusting to the States the level of payments from the Federal trust for providers' services.

State rate regulation of hospitals would be ill-advised for a number of other reasons. These include lack of expertise or experience in complicated reimbursement areas as well as the imposition of another strata of bureaucracy. There is absolutely no reason to shift the burden of reimbursement reform to the States. As matters now stand, most States are finding difficulties in administering medicaid in a timely and efficient manner. Mr. Duncan attempts to correct some of the more glaring problems in H.R. 13080, the House counterpart to Senator Talmadge's reform bill. We have testified in support of those provisions before the Senate Finance Committee's Health Subcommittee. But even if these problems are corrected, we oppose the interference of State governments in the administration of medicare.

CONCLUSION

We believe a medicare reimbursement reform bill should be drafted by the subcommittee in order to provide meaningful economic incentives for efficiency in hospital management.

Thank you for this opportunity to present our recommendations for revising the hospital reimbursement system.

Mr. ROSTENKOWSKI. Thank you, Mr. Bromberg and Mr. Bradley.

On page 17 of your testimony, you note that you know of no other industry in which income taxes are not recognized as an operating expense for purposes of cost-based reimbursement or rate of return. Can you tell us where, with the possible exception of certain utility type settings, which I do not believe you are advocating, income taxes paid are included as a before-profits cost? We certainly do not recognize Federal taxes paid as an expense in calculating Federal tax liability either for individuals or corporations.

Mr. BRADLEY. Mr. Chairman, we are referring to the cost reimbursement program and to our knowledge, at least, in a cost-based type program, income taxes are recognized as a cost. We know of no illustration where in a cost reimbursement program, they would not be recognized.

Mr. BROMBERG. I can add to that, Mr. Chairman, even where you have Federal agencies which regulate rates whether it be the CAB or the Federal Power Commission, for example, every manual published includes the phrase Federal, State and local taxes and other taxes and operating expenses so it is true at the State level in terms of the power companies and it is true at the Federal level for regulated carriers.

The only area we know of where taxes are not included are procurement contracts where the Defense Department, for example, issues a cost plus contract to buy 100 parachutes but there the return is not a percentage of equity but of gross. In all of our experience in one way or another, income taxes are recognized as a cost or the rate of return is great enough to be an after-tax rate.

Mr. ROSTENKOWSKI. Under the present practice of hospitals in your association, do high-level management officials receive incentive bonuses for efficient operations?

Mr. BRADLEY. Yes, there are various plans or incentive compensation programs. They range from the development of a bonus or incentive compensation program at the individual hospital level extending normally to the administrator, assistant administrators and in some cases, to department heads as well as to corporate facilities in the multiple facilities corporations.

Mr. ROSTENKOWSKI. Under a prospective reimbursement system, what would you expect your member hospitals to do with moneys that they would be allowed to retain for performing better target figures?

Mr. BRADLEY. I think as in the past that much of that money would obviously be reinvested in accordance with planning principles in the individual facilities or used to secure equipment or keep up with modern technology.

Also, much of it would be used in incentive compensation pools from which additional compensation would be paid to the employees who made the savings possible.

Mr. ROSTENKOWSKI. Are you talking about better performance?

Mr. BRADLEY. Better performance, a program which would reward those who contributed toward the over-all efficiency of the operation.

Mr. BROMBERG. I would add one thing to that and there is also the distinct possibility that any additional moneys received under the medicare and medicaid program could be used to hold down the rate of inflation and charge increases to other patients.

One fact that is not brought out when we talk about hospital inflation and examine indexes and rates and costs and charges, is that medicare and medicaid are never included. For every dollar that medicare and medicaid does not pay and is then shifted to the private sector shows up in the indices. Hopefully a system of equitable reimbursement would work to hold down the rate of inflation as it affects the private patient.

Mr. Rostenkowski. What would you recommend to the committee?

Mr. Bradley. I have had the experience of working in both the not-for-profit and for-profit healthcare systems for the last 25 years, the majority of that time being spent in the not-for-profit sector. What pertains specifically to for-profit or not-for-profit must be considered in terms of exceptions to either.

For the most part, the investor-owned or for-profit facilities have attempted to apply the techniques that have been successful in varying degrees in other forms of industry.

As an example, we have discussed on many occasions the percentage of hospital dollars spent for payroll. The measurements that we find most comprehensive in discussing our progress, our patient days and patient hours per patient day, as one example.

The present program does not provide any incentives to carefully consider whether or not the wages paid in an individual hospital represent those wages that are necessary to provide quality care as well as contain costs.

If you take a 100-bed hospital with an 80 percent occupancy rate that hospital would be producing about 29,000 patient days a year.

Using a figure of 18 hours per patient day of work, with an average payroll of about $4.50 an hour, the cost of labor represents about 64 percent of the total cost of that hospital.

If the application of industrial engineering techniques combined with rescheduling and proper educational motivation and in-service techniques resulted in a 15-hour patient day at the same rate, you would drop your cost per payroll to about 45 percent. This would be close to $400,000 a year in savings in payroll on the basis of reducing the hours per patient day from 18 to 15. This is not an impossible task and is illustrative of one of the many ways in which investor-owned hospitals strive to operate in the most efficient manner possible without any sacrifice to quality of care.

The investor-owned hospitals today have the incentive to affect that sort of cost containment because they are competing with the not-for-profit hospitals through the respectively determined charges such as in bill charge States or cost plans and the only way they could make a profit would be to apply these techniques. If all hospitals were allowed to retain those dollars saved in one form or another you would see a greater effort placed on the reduction of costs such as in payroll. That is only one. There are many, many other areas in terms of sharing costs, sharing services, the economies of scale that are available that are not really practiced by many hospitals today.

Mr. Bromberg. Mr. Chairman, perhaps it would be interesting to turn the question around and look at where the incentives are today.

The way the program currently operates, what you are really saying, if you were saying it to someone in private industry would be, "Mr. Executive, your salary will be determined on December 31 and not January 1. You will have an expense account but it will be open-ended. Go out and spend what you can. As long as you can justify it, we will pay for it."

What Dr. Bradley was suggesting is 180 degrees from what we have today under the medicare program.

Mr. Rostenkowski. Thank you.

Mr. Duncan will inquire.

Mr. Duncan. Thank you, Mr. Chairman.

I would like to compliment our guests on the fine statement you have made but I would like to ask one question.

Have the costs in the for-profit hospitals been increasing?

Mr. Bradley. I believe we find all our costs increasing. As I have been tracking in our group for the last 7 years, I am seeing a lesser percentage of increase with each passing year, each indicating hopefully, some potential containment of costs. I don't believe that we could say that they have reduced, but we are trying to contain them and the rise is not as great as it had been in the past.

Mr. Duncan. Has the rise been as great in the for-profit as in the not-for-profit hospitals?

Mr. Bradley. I don't have those figures with me but I think they would be comparable.

Mr. Duncan. Do you have any views as to what would be the best kind of prospective reimbursement mechanism?

Mr. Bromberg. I wish we did, Congressman. That is a key question. We can all say that we have to move away from cost toward prospective. But we cannot do so without the proper experimentation and experience. We can suggest three or four experiments we would like to see tested. There are three generic types of prospective rates and under those there are literally thousands. There are prospective rates which are negotiated, and those determined by a formula and a prospective rate set by a public utility type commission.

We would like to see experiments for example, on the basis of dollars per diagnosis or a negotiated discount. I am one who believes that medicare is entitled to a discount. I just think it is too big now. If Blue Cross has 30 percent of the market, they can make a case as to why they should get a discount but I think it should be negotiated and based on some equity, maybe 3 or 4 percent.

I would like to see an experiment based on a negotiated inflation rate, saying we will take the rate this year plus 80 percent of the hospital charge nationwide or regionally.

There is an experiment in Florida which I find quite interesting. Basically, it says your present charges are accepted but next year we will pay you an increase of 80 percent of the southeast regional index. It is similar to section 10 of your bill. Section 10 of your bill is a promising replacement for cost reimbursement and has incentives but we believe there should be predetermined prospective determinations made such as those.

Mr. Rostenkowski. Mr. Cotter?

Mr. Cotter. No questions.

Mr. Rostenkowski. Mr. Burleson?

Mr. Burleson. No questions.

Mr. Rostenkowski. Thank you, gentlemen.

Mr. Hollander, welcome to the committee. If you would care to summarize your statement, you may do so.

STATEMENT OF NEIL HOLLANDER, VICE PRESIDENT FOR HEALTH SERVICES OF THE BLUE CROSS ASSOCIATION

Mr. **Hollander.** Thank you, Mr. Chairman. I am Neil Hollander vice president of the Blue Cross Association, the national coordinating agency of the 70 member Blue Cross plans in the United States and Puerto Rico.

I thank you for the opportunity to share with you our thoughts about the costs of hospital care, and how the present medicare hospital reimbursement system should be revised to promote more efficient containment of those costs.

In keeping with the guidelines for this hearing, I shall limit my presentation to 20 minutes. However, I have submitted for this committee a longer statement containing detail on all of the points I shall summarize here. I would ask that it be included in the record.

Mr. **Rostenkowski.** Without objection, it is so ordered.

Mr. **Hollander.** The views which I shall present reflect the knowledge and experience gained by the Blue Cross organization through the administration of both governmental and underwritten health care financing programs.

Section 3 is the shortest because it is the one we commented on before and is most generally understood.

Another factor is the breadth of medical technology. Medical technology has grown at a geometric rate. While some advances in medical science and technology offer opportunities for better care, others can create serious economic problems. New expensive techniques frequently achieve widespread popularity without careful evaluation of their real effectiveness or the need for them. An outstanding example is computerized axial tomography or CAT scanners which are proliferating.

Still another factor of concern is the improper use of services. There is evidence of unnecessary or inappropriate use of health care services by patients. A number of health maintenance organizations have reported hospital use rates only half those experienced by the traditional health care system.

Another factor which deserves mention is intensity of care which can be caused by physician fear of malpractice suits—an can result in so-called defensive medicine which produces many more diagnostic tests than would otherwise be necessary.

The last factor I want to list is employee productivity. Increases in the numbers and types of hospital personnel over the past few years raises questions about employee productivity. Perhaps the most important factor and one not found in the hospital itself is the need for individuals to accept responsibility for their own health, improve their lifestyle, diet and many other things that determine health care—and the need for society to improve employment, educational environment, and the total environment. That problem is easier to diagnose than to cure, but all of us together must one day face up to the challenge as to how to motivate people to change their habits, how to clean up the total environment, and how to eliminate industrial and occupational health hazards. These are complex and challenging questions.

Now, it is necessary for me to establish some background.

Whether we are seeking long term solutions to the cost problem or only immediate results, we must as a Nation begin to set clear, concise national health goals.

The Secretary of Health, Education, and Welfare should have the primary responsibility for proposing national goals with the assistance and advice from both public and private organizations including planning agencies—employers, unions, health-care providers, Blue Cross plans other health insurers and the general public.

As the goals are established, the public and private sectors, including the Congress and Federal agencie, must work more closely together to coordinate and focus on regulatory and administrative actions to achieve national health goals. Too often in the past, health policies have been vague or inconsistent, followed by implementation efforts that are unnecessarily fragmented, duplicative or counter-productive

Now let's look at hospital reimbursement.

A prospective payment system or a retrospective one with financial incentives can help promote better day-to-day efficiency. However, if changes are introduced in a vacuum, the savings would be relatively small and probably only would be short term. That is because the prime determinants of hospital cost are associated with health planning and utilization review. Both have influence on long term problems I have talked about such as duplication of facilities and services, uncontrolled medical technology, medically unnecessary or inappropriate use of services, inefficient day-to-day operations, and so on.

The biggest potential would appear to lie in incentive features that strengthen the health planning and utilization review activities that are carried out within the community and within individual hospitals.

One key point to remember is that the design of any incentive system, whether prospective or retrospective, depends upon the objectives to be achieved and the context of the environment in which they will be implemented.

The important thing is whether the system has proper incentives in it, not whether the system is prospective or retrospective. There is no basis in logic or fact to suggest that a retrospective approach with imaginatively designed and administered incentive features cannot yield effective or even more effective results than any particular prospective system. A number of different kinds of prospective and other incentive payment programs have already been used. Unfortunately, I can't say any one or two of them have shown they can achieve the desired results. There are several reasons.

For one thing, evaluation of their effect is very difficult. We don't yet have a way to measure the impact of the programs on cost.

There isn't enough data covering enough time to provide a basis for analysis or comparison.

For another, participation by providers and payers on a voluntary basis has been limited and provides only a small base of experience. Nevertheless, the prospective programs now being tried deserve support and should continue at least until enough evidence is collected to determine the best directions for payment programs to take.

The same comments apply to current programs that reimburse providers on a retrospective basis but have features which support effective planning and utilization review.

Because of its national character, its significance in the market and its legislative authority, medicare is in a unique position to stimulate and assure commitments to more design and more testing of various approaches to payment. But it would be a serious mistake to assume any single method can be designed for medicare that can effectively deal with all of the complex issues surrounding the payment in the health care field.

National use of a single method without having fully tested and evaluated it could continue the present cost spiral or even make it worse or seriously affect the ability of the provider to deliver quality health care.

As mentioned earlier, there is a need for more support of local iniatives where several incentive systems are already in use. They would be enhanced by increased medicare participation, and the cost to medicare would be small compared to planning, implementing and evaluating an incentive system from scratch.

Much more information on all those points is available in our full statement submitted to the committee.

I would now like to go to the third section of our statement and discuss our recommendations for specific provisions of medicare. It is our recommendation that current medicare hospital systems be altered to enable hospitals to choose either (1) a medicare prospective or incentive payment program from either programs developed by the Secretary of Health, Education, and Welfare of those locally developed and approved by medicare or (2) a medicare retrospective payment method with certain revisions and incentive features contained in medicare law and regulation.

These revisions should permit the managers of the hospital to determine what various courses of action they can follow and what effect the result of their decisions might be on cost and revenue.

Specific incentives should be built into the system to help accelerate the design and use of cost containment measures.

Further, an incentive system should reward acceptable cost performance. The idea should not be only to penalize bad performance but to reward the good.

The Congress recently took an important step toward establishing budgetary limits regarding medicare, and we understand that action must now be taken to make the necessary decisions to bring about the desired results.

Hard choices will have to be made by the Congress, deciding whether to limit the benefits of medicare coverage or to generate more efficient systems of incentive reimbursement which would have a strong potential to contribute to overall efficiency by encouraging health care managers to take the steps necessary to make the whole hospital system perform better than it has in the past.

If the decision is to go with incentives, they would have to take into account several factors related to the incurrence of cost in the hospital.

Incentive features have an impact on other determinants of total program costs such as utilization rates for the shift from inpatient to outpatient services. Because the system can affect those specifics, they must be carefully considered in the cost containment approach.

Of all the possible areas for providing incentives, the ones that seem most important are those concerned with capital expenditures and relating to operating expenses for new or modified services. This is particularly true of capital expenditures for bricks and mortar—short run and long run.

There is the need for designated agencies to plan without pressure to accept new applications and the current level of cost increases.

During the initial period, it might be necessary to establish a more restrictive approach that sets forth realistic criteria, or stimulating improvement in the health care planning process provided under Public Law 93–641, the Health Planning and Resources Development Act.

This approach could limit the allowance of payment only to capital projects approved before its adoption, or projects for which construction is underway or for which the hospital already has a firm contract, or those required to maintain compliance with governmental or private safety standards for patients and employees.

Also, all projects would have to have full approval of a fully designated State planning and development agency.

Two other programs illustrate the kind of positive features that are needed.

One of the most important is the measure introduced by Senator Talmadge and Mr. Duncan of your committee to provide for continued capital payments for facilities which are closed. We supported that provision in our testimony before Senator Talmadge's committee on July 30.

Another is the "swing bed" experiments now being conducted under medicare in three areas—changing acute care beds and underused facilities into long-term care beds where shortages of long-term care beds now exist.

All of these proposals are complex and we must not make the mistake of expecting immediate results.

There are no simple national solutions. There is no single solution of any kind. The medicare program structured as it is for national policymaking with centralized administration through third-party intermediaries is in a prime position to design, test, and evaluate local approaches in concert with providers and other payers, and to do so in the context of national objectives.

Motivation and commitment are the key to the future success of various cost containment initiatives. The reforms we have suggested will not produce perfect results or immediate results, but they will, if effectively implemented, produce good results. They focus on the advantages of encouraging flexibility and innovative management, which we believe are critical, and they represent an enlightened public policy, that is, to have as many people working on the problem as possible in as many different ways as can be creatively designed with the common incentive of more efficiency.

In order to encourage the needed flexibility, the medicare program must be willing to take risks in designing and testing various incentive approaches, aware that some may be more aware or productive than others, but recognizing also that many different types need to be tried.

In the final analysis, incentive payment systems and other cost containment tools are nothing more than approaches. Whether their potential is realized depends upon the commitment of both providers and payers to make them work and the extent to which they focus on end results. We need to give managers incentives to manage their resources wisely but leave them the flexibility to decide how best to do that within a broad based system.

I thank you very much for your time and attention today, gentlemen.

I have greatly condensed our reviews for this oral presentation, and I will refer you to the detailed statement which was submitted for your consideration.

If there are any questions, I would be glad to answer them now or by furnishing additional information in the future.

[The prepared statement follows:]

STATEMENT OF NEIL HOLLANDER, VICE PRESIDENT, HEALTH CARE SERVICES, BLUE CROSS ASSOCIATION

Mr. Chairman, and Members of the Committee. I am Neil Hollander, Vice President of the Blue Cross Association, the national coordinating agency of the 70 member Blue Cross Plans in the United States and Puerto Rico.

I thank you for the opportunity to share with you our thoughts about the costs of hospital care, and how the present Medicare hospital reimbursement system should be revised to promote more effective containment of those costs.

The views I shall present reflect the knowledge and experience gained by the Blue Cross organization through the administration of both governmental and underwritten health care financing programs.

On the government program side, the Blue Cross Association is a prime contractor to the Social Security Administration for the Medicare program nationwide. Individual Blue Cross Plans are subcontractors to the Association for this program. Many of our Plans also administer the Medicaid program in their territories.

On the underwritten business side, the Blue Cross organization serves more than 80 million members who are significantly affected by the rising costs of health care. In nearly all instances, we provide what is known as "service benefit", that is, full or neardy full payment for covered services, in contrast to "indemnity" or fixed cash benefits paid by many commercial insurance policies.

In 1975, we paid $13 billion in benefits for our subscribers, covering nine million claims for inpatient hospital care and twice that number—18 million—for outpatient and other ambulatory care.

Our Plans have contracts with 6,700 hospitals, covering both inpatient and outpatient services. In addition, 30 of the Plans are involved with more than 100 health maintenance organizations, mostly the prepaid group practice type, to help give our subscribers a choice of the kind of care they will receive.

We have been most closely identified with hospital coverage. But now, to a significant degree, we also cover diagnostic laboratory and x-ray services, dental care, home health care, prescription drugs, vision care, nursing home care, ambulance service, preventive care, and outpatient psychiatric services.

Because of consumer demand for broader benefits, our payment would have gone up over the years even if the cost of care had remained constant. However, costs have increased significantly.

In the comments to follow, I intend to present information and recommendations concerning each of the nine specific issues posed in your announcement of this hearing. However, in analyzing nine issues, it was apparent that many were interrelated, with the answers to some contingent upon answers to one or more of the others. For that reason, our responses to the nine issues are not in the precise order or format as you presented them. The discussion is separated into three major parts. The first two sections generally correspond in content to the first and second issues posed by this Committee. The third section presents a number of general and specific issues, options and recommendations for reform in current Medicare hospital reimbursement incentive programs, encompassing issues three through nine posed by the Committee. I should mention here, however, that this statement does not address all the Medicare hospital reimbursement reform issues posed in Senate bill 3205 sponsored by Senator Talmadge and its House counterpart, H.R. 13080. I would refer you to our testimony of July 30, 1976, before the Senate Finance Committee for that information.

I. FACTORS CONTRIBUTING TO THE CONTINUING RISE IN THE COSTS OF HOSPITAL CARE

As a point of reference, it may be useful to characterize the pre-Medicare period of inflation as primarily "cost-push," a major factor being a "catch-up" in the relatively low wage rates in the health industry. A catch-up was also occurring in terms of modernization and replacement of outmoded health care facilities, supported principally through federal subsidies beginning in the late Forties with the advent of the Hill-Burton Program.

In the lates Sixties, with the advent of Titles XVIII and XIX of the Social Security Act, in combination with the Hill-Burton Program and increased benefit coverage for more employees and their families through private health insurance and prepayment mechanisms, rates of health care cost inflation dramatically increased. Inflation during that period can be generally characterized as "demand-pull," with the general population increasingly seeking the best care possible and health care providers, particularly the hospital industry, reacting to and interpreting that demand by providing more services and applying new and improved medical technology.

The 1970s can be characterized as a period of combined cost-push and demand-pull health care inflation. The health care industry is being subjected to higher input prices—wages, supplies, energy, equipment, construction, et cetera. Because many of these expenses are outside hospitals' control, this cost-push component of inflation can be expected to continue in the future unless general inflationary problems in the economy are effectively resolved.

Whether the demand-pull component of health care cost inflation continues in the future largely depends upon the individual and combined efforts of a variety of entities impacting on and impacted by the health care delivery system.

While demand-pull inflation was caused by factors which resulted in more people having better access to higher quality care to meet their health care needs, it appears that those gains may not have been achieved in the most efficient and cost-effective manner. Evidence of this includes duplication of facilities and services which can be found in many metropolitan areas.

Medical technology has grown at a geometric rate. While some advances in medical science and technology offer opportunities for better care, others can create serious economic problems. New expensive techniques frequently achieve widespread popularity without careful evaluation of their real effectiveness. Some innovations may eventually show little improvement over older, less expensive methods. Some may be so expensive that widespread use will draw limited resources away from other important needs. And, too often, new techniques are added to older ones, rather than replacing them.

There is also the problem of cost brought about by planned obsolescence of equipment as manufacturers regularly release bigger and better models which actually provide only small additional benefits, especially when compared with the additional cost.

Improper use of services is another important concern. There is evidence of unnecessary or inappropriate use of health care services by patients. A number of health maintenance organizations have reported hospital use rates only half those experienced by the traditional health care system. And it has not been uncommon for health planning agencies to find large differences in hospital use in various areas within their jurisdiction.

I can't leave this subject without mentioning the intensity of care which can be caused by physician fear of malpractice suits. "Defensive medicine" results in many more diagnosic tests than would otherwise be necessary.

Increases in the numbers and types of hospital personnel over the past few years raise questions about employee productivity. A portion of the increase may relate to growing specialization and division of labor as a result of increased technology, yielding better quality of care.

These are some of the key elements or symptoms of the health care delivery system's cost problems which result from the demand-pull phenomenon we've been experiencing over the past decade.

Many in the health field agree that the underlying causes of these problems are twofold.

First, as Walter McNerney, President of the Blue Cross Association has pointed out, the real long term solution to the health care cost problem does not lie in the health field as we know it today. It lies in reducing the need and demand for health care. And that means somehow influencing people to accept responsibility for their own health, reducing their dependence on the health care system.

There is increasing awareness that no matter how much we spend on disease treatment and accident repair, it will not make people healthier. It is argued by some, in fact, that we have reached a point of diminishing—and perhaps negative—return from our continuing and growing investment in health care services.

Health is influenced by a multitude of factors. such as lifestyle, social and physical environment, income, diet and many other things. Health itself does not depend entirely upon medical care; nor even primarily upon medical care.

We must begin to look at the cost and benefits of various forms of primary care, preventive medicine, environmental and occupational initiatives and health education of the public, as well as traditional health care services. We need to measure and compare and clearly determine which of those, in which proportions, will truly produce the greatest level of real health for the money and resources spent.

That problem is much easier to diagnose than to cure. For instance, how to motivate people to change their habits, how to clean up the total environment and how to eliminate industrial and occupational health hazards are complex and challenging questions.

A second cause of the health care cost problem relates to the nature of the incentives operating within the health care delivery system, particularly on the hospital industry, which influence levels of efficiency and cost-effectiveness.

The hospital payment or rate-setting mechanism is a key component of the incentive system that, if imaginatively designed in combination with four other generally recognized tools, bears significant potential for moderating hospital cost inflation while the longer term, holistic solutions to the health care cost problem are being sought. These four other tools are health planning, utilization review, alternative delivery systems such as HMOs and innovative health care benefit packages.

Before moving to a discussion of what is being done now, and needs to be done in the future, with the hospital rate-setting mechanism—by the Medicare program and others—to enhance its effectiveness as a cost containment tool, a basic point needs to be made. The question of what needs to be done is to be supplemented with an understanding of how we need to make the policy and organize to do it.

Whether seeking long term solutions to the health care cost problem or more immediate results through restructuring of the incentives in the health care system, we must as a nation begin to set clear, concise national health goals. The Secretary of HEW should have primary responsibility here. The National Council on Health Planning and Development being established under P.L. 93–641, state and local planning agencies and a variety of other organizations, such as Blue Cross Plans, major employers, unions, and health care providers, have a responsibility to actively support and advise the Secretary in this critical effort.

As those goals are established, a variety of entities in the private and public sectors—including Congress and various agencies within the executive branch—must work more closely together to insure that legislative, regulatory, administrative or other actions to achieve national health goals are effectively coordinated. Too often in the past, health policies have been vague or inconsistent, followed by implementation efforts that are unnecessarily fragmented, duplicative or counter-productive.

Congress recently took an important step toward establishing budget limitation on governmental expenditures. As this applies to the Medicare program, action must now be taken to make the decisions necessary to bring it about. Hard choices must be made by Congress between limiting benefits or taking steps to generate a more efficient and effective program. Incentive reimbursement systems have the potential to contribute to the latter, encouraging health managers to take the actions necessary to make our hospital system perform better.

II. NEED FOR ACCELERATED DESIGN, TESTING, AND EVALUATION OF ALTERNATIVE PROSPECTIVE AND OTHER INCENTIVE PAYMENT PROGRAMS BY THE PUBLIC AND PRIVATE SECTORS

The hospital rate-setting mechanism—whether rates are determined by a governmental agency or through negotiation with third-party payers—depending on how it is designed, can play several key, alternative roles as a cost containment tool.

For instance, a prospective payment system, or even a retrospective payment system with financial sanctions or rewards related to a hospital's level of cost incurrence may serve as a vehicle for promoting improved day-to-day operational efficiency of the institution; e.g., more productive use of nursing staff personnel, more prudent purchasing practices, et cetera. One could expect, however, that if this is the only incentive focus and objective of the hospital payment method, the "cost-savings" to be achieved would be generally limited, and of a short-term nature. This is because health planning and utilization review decisions are the prime determinants of hospital costs, and impact on the major elements of the short-to-near term hospital cost problem, i.e., facility and service duplication, uncontrolled medical technology and the provision of medically unnecessary or inappropriate services.

Most of the potential of the hospital rate-setting mechanism as a cost-containment tool would therefore appear to lie in the design of prospective or retrospective payment incentive features that augment health planning and utilization review processes carried out within the community and individual health care institutions.

Some examples of how prospective or retrospective incentive payment programs can be designed to augment the health planning decision making process are as follows:

Section 1122 of the Social Security Act, wherein the Medicare Program bases its decision about payment of certain capital expenditures on whether a state health planning agency has approved or disapproved the need for the proposed project.

Prospective or retrospective payment systems where irrespective of health planning agency recommendations on the need for existing and/or new facilities and services, the rate-setting process makes the final decision on the appropriateness of facilities or services for payment purposes.

Target occupancy rate payment limitations under third-party retrospective payment programs, wherein a unit cost payment penalty applies to hospitals operating below a given level of capacity.

Continued allowance of certain capital costs of hospitals under prospective or retrospective payment systems which close or convert excess operating capacity.

Prospective regional hospital expenditure limitation program, being currently tested in Rhode Island, wherein a total resource constraint is placed on all of the hospitals in an area, with the decision left to the hospitals and/or the payers as to how the resources are to be allocated among the institutions to insure highest total-cost-effectiveness.

Some examples of how prospective or retrospective incentive payment programs can be designed to augment utilization review processes are as follows:

Prospective rate-setting systems, or retrospective payment systems with cost limitations, employing a case rate (e.g., average cost per admission) unit of payment, to promote medically necessary and appropriate lengths of patient stay and use of professional ancillary services in the most cost-effective mix.

Third-party payer retrospective claims denials related to the provision of medically unnecessary or inappropriate services in hospitals not deemed to have an effective utilization review program.

Third-party payer monitoring, but no retrospective denials of individual claims based on utilization review considerations, of hospitals deemed to have an effective utilization review program.

A key point to bear in mind is that the design of any particular incentive payment system—whether prospective or retrospective—depends upon the objectives to be achieved. Those objectives are determined by an environmental assessment at the regional or local level of (1) the relative magnitudes of various components of the cost problem (e.g., unnecessary duplication of facilities and services, uncontrolled medical technology, medically unnecessary or inappropriate use of services, inefficient day-to-day operations, et cetera) and

(2) the existence or absence of other mechanisms in the area to effectively deal with the priority problems (e.g., state and local health planning agency capacities and capabilities, regional and individual provider utilization review capacities and capabilities, etc.)

A second important point is that having the proper incentives in the rate-setting mechanism is the critical factor, and not whether the method is prospective versus retrospective. There is no basis in logic or fact to suggest that a retrospective approach with imaginatively designed and administered incentive features cannot yield as effective or more effective results than any particular prospective system. Also, to the extent that any prospective system bears the potential for significant adjustments or exceptions during the fiscal year or following its completion, it becomes increasingly retrospective in actual practice.

I would like to describe some of the key prospective and other incentive payment programs being employed currently, and the state of knowledge concerning their relative impacts.

Unfortunately, at this time, we cannot come forward with a specific design for one or two payment approaches which we can say have demonstrated that they can achieve the desired objectives. Several factors contribute to this dilemma:

(1) To date, there have been no evaluations which would provide comparative analyses of the impact of the payment approaches currently employed by various payers. The Social Security Administration has contracted for independent evaluations of some of the forms of payment currently in place. However, these reports have not been released. These evaluations may not be conclusive, however, since they focus only on single applications of a limited number of payment approaches.

(2) Evaluation is a difficult process. The issues are complex, not only as they relate to cost and what brought about change, but also as they relate to the quality of care rendered. Furthermore, programs were designed with different objectives (i.e., impacting operational efficiency only) and, therefore, the evaluation must consider the system's effectiveness in relation to its objectives. While the impact of the payment system on the quality of care in the near term and particularly in the long term can be significant, the ability to measure this impact is limited at this time.

(3) Data has not been accumulated on a uniform basis over a sufficient period to provide a basis for the necessary analysis not only of the various components and related impacts on individual payment programs but, importantly, on a comparative basis. A key problem here, of course, has been the lack of specific provision in the design of payment programs to provide such evaluative data.

(4) Limited participation by providers and payers on a voluntary basis has provided a limited base of experience for evaluation. Further, in many situations, the payment mechanism under study impacted on only a limited portion of the hospital revenue since not all payors participated. This diminished the potential for impact at the outset and provided the opportunity for shifting the impact to other payers.

(5) The evolutionary change of the payment mechanism from retrospective to prospective has made it difficult to analyze the impact of various elements of a payment mechanism.

Nevertheless, we believe that there are programs currently operational or being tested which merit support in whole and in part and, therefore, should continue at least until more evidence is accumulated as to the appropriate direction for payment programs. These programs can be generally divided into the following categories:

(1) Prospective cost based formula approach using a historical unit cost base adjusted for price inflation and other factors. The most notable example of this approach is found in New York State. This approach to prospective payment is probably the simplest to administer since it applies a single formula to all providers or classes of providers. Further, the level of payment can be carefully controlled through the use of the various indices. However, the method may not be responsive to individual provider's real needs or actual experience with numerous appeals or interim adjustments. In addition, the impact on provider payment and services may not be predictable. The key element in the "success" of such a program is the "formula and its components" used in determining the prospective payment rate.

(2) Prospective cost based programs involving analysis and negotiation of budgets. Blue Cross Plans in Connecticut; Colorado; Cleveland, Ohio; Pittsburgh and Wilkes Barre have adopted or are experimenting with this approach.

Administratively this method may be the most difficult and time-consuming because of the necessary analysis of individual hospital budgets and the sometimes lengthy negotiation process. Impact in terms of payment rate largely depends on the skill of the negotiators and the depth of analysis.

This method should be responsive to individual provider needs and can be a rational approach to the provider as an entity and to community need.

Many administrative problems can be alleviated through careful screening against pre-established criteria and other layering of the analysis process to limit hard negotiation to those situations where there is greatest potential for impact.

(3) Prospective cost based involving budgets with formula/cost cap features. Blue Cross Plans in Pittsburgh, Pennsylvania and Rhode Island are utilizing this approach.

It has many of the characteristics of the negotiated budget method noted above with an important difference—a cap is placed on the amount that will be allowed for payment.

The cap may represent a communitywide limitation on health care expenditures for provider care or may relate to a limit on payment to an individual provider. The design and determination of such a cap along with relating negotiations to those limitations can be very difficult.

On the other hand, this appears to represent a logical, systematic approach to funding health care in a given area.

(4) Prospective charge based programs involving analysis and negotiation of revenue needs derived from operational and capital expenditures. Administratively, this one would encounter the same types of problems seen in the budget negotiated on a cost basis. Additional difficulty may be encountered in that rather than dealing with an entire budget, revenue needs are being dealt with on a periodic and limited basis.

Furthemore, very careful definition of financial requirements must be made for inclusion in charges. In this regard the financial requirements should be no different than under a "cost" based program.

Careful consideration must be given to the utilization impact of payment on the basis of individual charges for individual services. This charge approach does not seem consistent with the "bulk purchase of service" practices of major third party payors.

We have attempted to enumerate some of the strengths and weaknesses of the major prospective payment approaches. These characteristics apply and any of the methods can be implemented whether the authoritative base and control rest with a governmental entity (i.e., state) or with the private sector.

III. ROLE OF MEDICARE PROGRAM IN BRINGING ABOUT ACCELERATED DESIGN, TESTING AND EVALUATION OF PROSPECTIVE AND OTHER INCENTIVE PAYMENT APPROACHES

Because of its national character, its significance in the market and its legislative authority, Medicare is in a unique position to stimulate and insure commitments to accelerated design and joint testing of alternative prospective and other incentive approaches.

As we indicated, a variety of prospective and/or incentive payment systems are already fully operational or being operated on an experimental basis and they could be enhanced with Medicare participation. In these instances, design effort, start-up time and implementation cost would be minimal.

Using a number of different approaches to payment in Medicare is feasible. Since it would be necessary to develop criteria for aceptance of a method, commonality related to objectives and elements of financial requirements would be established. Beyond that, only the technical approaches to paying individual providers would be different.

Necessary modification of a method, once it is in place, tends to be slow and must be done on a piecemeal basis.

Permitting more than one method to be used in a variety of locations avoids these pitfalls. Further, under the constraint of general guidelines and objectives, it is desirable because:

(1) More experience and research are needed. As we have indicated, no one method has been demonstrated to be the most appropriate.

(2) Methods could be developed which wold be responsive to unique regional characteristics. To the extent that control or operation of the program can be brought closer to the provider, impact and responsiveness are increased.

(3) Ongoing comparisons of the strength and weaknesses of the components of various payment methods could be made.

(4) Acceptance of prospective payment would be stimulated, thereby increasing its potential impact as well as requiring the provider's participation in a single payment mechanism.

(5) Existing knowledge, experience and development that has already taken place in the field would be fully utilized.

Medicare, with decentralized administration by local intermediaries, is already organized in a manner to implement effectively a number of different payment approaches. By capitalizing on this existing structure, the need for additional layers of governmental administration is significantly reduced.

The Blue Cross organization is ready in its role as intermediary and as operator of a number of innovative payment methods to continue to contribute in this area.

Predetermined design criteria, ongoing evaluation and the economic incentive related to participation by the parties at economic interest would minimize the potential for uneven or inappropriate performance in the various settings. This does not mean, however, that with a variety of methods there would not be mistakes or failures. These will be important learning experiences with minimal national risk.

The Medicare hospital reimbursement system currently includes three basic features to promote improved efficiency and cost-effectiveness among participating hospitals. These are Sections 221, 222, and 223 of Public Law 92–603. In our opinion, these provisions have had minimal impact on the rise in hospital costs and, more importantly, in stimulating increased design, testing and evaluation of prospective and other incentive payment approaches in concert with participating hospitals and other payors.

Administration of the Medicare hospital reimbursement system in areas other than Sections 221, 222, and 223 has often been reactive, piecemeal and fragmented—focusing on potential abuses arising with respect to specific defined elements of allowable cost; more concerned with the process and components rather than the overall bottom-line; and more concerned with limiting what the Medicare program will pay for (e.g., elimination of the 2% cost allowance feature, withdrawal of the current financing provisions, attempts to eliminate the nursing cost differential, etc.) than seeking to motivate providers to test new incentive payment approaches and improved performance.

The Medicare program undoubtedly has created a greater awareness by hospitals of the costs they incur, and has raised the level of hospital cost accounting practices. However, a system of uniform hospital cost reporting cannot be truthfully said to exist under the program even today.

Overlying all of the foregoing problems is the recent procedent-setting action by Congress to place specific limits on the Medicare program budget.

Given these complex yet interrelated problems—in an environment which demands more aggressive design, testing and evaluation of a variety of prospective and other incentive payment approaches—we recommend the current Medicare hospital reimbursement system be altered to enable hospitals to choose either:

(1) A Medicare prospective or incentive payment program from either:

(*a*) one or more programs which have been developed and promulgated by the Secretary; or

(*b*) programs developed at the state or local level, applied for by hospitals and/or third party payers and accepted as eligible for Medicare participation.

(2) A Medicare retrospective payment method with certain revisions in the regulations.

Implementation of the revisions to the current retrospective method should begin as soon as appropriate design and promulgation can be completed. Implementation of other prospective or incentive payment programs would require more extensive preparation.

We believe that it is necessary and feasible that the Secretary be required, within one year from the date of enactment, to

(1) promulgate at least one prospective or incentive payment program; and

(2) establish the administrative means to receive and process applications for programs developed on a state or local level; and

(3) accept a sufficient number of programs developed at the state and local level to demonstrate compliance. The need to undertake constructive change, in this instance, outweighs the risk of participating in certain payment programs without all of the reporting and evaluative criteria in place at the inception

of those programs. All of the features to complete the necessary administrative procedures and guidelines should be in place no later than 2 years from date of enactment.

Under this timetable, we would anticipate that by the beginning of the third year after enactment, Medicare would be participating with the private sector in a significant number of prospective or incentive payment programs.

Issues and Recommendations With Respect to Development, Application for, Review of and Administration of Options to the Basic Retrospective Payment Approach

The criteria for designing as well as evaluating programs must be well defined. These criteria would serve as the basis for any prospective payment systems introduced by the Secretary, the hospital industry, a third party payer or a combination thereof. We believe the following elements are essential for the successful design of any payment system:

1. *Results at Orientation*—the payment mechanism should be oriented toward results, not process. It should be based on the policy approach to rate determination (e.g., predetermination of allowable rates of increase with operating decisions left to the hospital, case rating, etc.). In addition, it should allow certain technical approaches (e.g., line item review, formula calculation, etc.).
2. *Equal Risk*—both payer and provider should be subject to similar levels of risk; i.e., the system should allow both rewards and penalities.
3. *Employee Participation*—any incentive rewards (savings) earned should be available for distribution, all or in part, to the medical staff and/or employees of the institutions.
4. *Significance*—the magnitude of potential rewards and penalties should be sufficient to motivate management and staff toward performance improvement.
5. *Uncontrollable Events*—the payment mechanism should allow negotiated adjustment for mutually agreed uncontrollable events such as substantial changes in volume or patient mix, legislative changes, natural catastrophies or other acts of God.
6. *Linkage to Health Planning Process*—the payment mechanism should reflect the reasonable costs only of existing and new health care services and facilities determined to be needed and appropriate by the designated health planning agencies.
7. *Linkage to Effective Utilization Review Process*—the payment mechanism should be linked to provide internal and, where necessary, external utilization review systems that assure the provision of only medically necessary and appropriate services.
8. *Quality Maintenance or Improvement*—the payment mechanism should not be so restrictive that the quality of patient services is jeopardized.
9. *Equitable Incentive System*—the reward and penalty systems should be designed so that the efficient hospital is not penalized and the inefficient hospital rewarded. At present, "efficiency" has no absolutes in the health care industry. Therefore, as a minimum, the reward and penalty systems should focus on the relative performance among "like" types of institutions.
10. *Financial Viability and Equity*—the payment mechanism must reflect the provider's total cost of operations, including (1) unrecovered costs due to patients' inability to pay, (2) beneficiary credit losses, (3) the costs associated with necessary working capital and financing approved capital facility and services projects, (4) reasonable rate of return and risk factors to attract needed capital to the industry, and recognize the risk assumed in performance-based payment systems and (5) any other costs of doing business as identified by the Secretary. Additionally, the payment mechanism must provide for equity between various payer groups by recognizing that costs incurred by an institution may differ between payers.

With these criteria, the various elements of the payment system should be designed to favorably impact on performance.

It must be emphasized, however, that quantitative data on the relative merits of the components of a payment system are not currently available. We believe that a wide range of alternatives must be explored. We offer these comments on some of the specific elements:

Unit of payment

The unit of payment must reflect an available statistic that adequately measures the Medicare program's utilization of the services of the institution. Additionally, the impact of the unit of payment on utilization of services in the facility must be considered.

Payment units that tend to have an upward thrust on utilization are individual charges for each service, per diem and, to a lesser extent, per case.

The more broadly defined units, such as share of total budget, not only define the amount to be paid, but by establishing total expenditures, no incentive is created for increased utilization.

We would encourage more programs using the share of financial requirements as expressed in budget and per case unit approaches.

The unit payment must also be sufficiently broad so as not to unduly restrict the provider's management flexibility.

Performance incentives

If any payment method is to be successful in containing health care costs or changing the delivery system, we believe incentives are needed that will promote changes in behavior.

Financial incentives which reward efficiency and effectiveness should be an important part of the payment methods developed.

The incentive payment should not become part of the future prospective payment base. The program should be structured to provide continued incentives to providers to maintain or further improve their efficiency. Incentives could be based on comparison with the provider's own projected performance and/or by comparison with performance of its peers.

Under a prospective system an obvious incentive is retention by the provider of the difference between the prospective amount and the actual amount.

One problem with incentives has been what the provider does with the additional funds in a comprehensive planning environment.

We would advocate that as part of an incentive program, persons directly responsible for achieving the performance level share in the incentive payment. One approach would be to distribute 50% of the amount received to employees under an approved plan in recognition of their contribution to the favorable performance. This provision has great potential for improving provider efficiency since it shares the incentive payment with those who are actually doing the job.

Separate incentives could be designed to encourage and reward achievement in specific performance areas, i.e., pre-admission testing, group purchasing and staff scheduling.

Incentives, or at least a protection from financial loss, are needed for providers which close or convert to alternative uses the space and facilities no longer needed. Separate payments which would serve to support the cost of such changes could provide needed impetus in this area. Under present reimbursement programs, no incentives exist to close facilities not needed since Medicare and other third party payers generally stop payment at the time of closing. A proposal along these lines had already been introduced by Senator Talmadge.

An important aspect of a prospective payment system is the risk element—that is, the negative incentive created when a provider fails to perform within the prospective rate. In such cases, the system should provide for:

(1) A plan of corrective action to eliminate the cause(s) of performance deficiency.

(2) Reconsideration of the base for the next prospective rate period so the problem is not perpetuated.

(3) Assessment of the financial viability of the provider as a result of the overexpenditure. In some cases, it may be necessary to make an additional payment to a provider simply to protect its financial viability even though the actions leading to the problem were inappropriate. In these cases, to qualify for such protection, there would have to be a clear plan of action to correct the deficiency and a clear demonstration of the continued need for that provider in the community.

In the design of a prospective payment mechanism, several other elements are significant:

(1) *The criteria used to evaluate the total level of payment and the change in the level of payment.* Here various methods of indexing, peer grouping and methods of screening for more intensive review would be applied and evaluated. The object of these would be to (a) insure overall reasonableness of the level of payment, and (b) reduce the administrative burden of detail review.

(2) *The nature and extent of the items which qualify for automatic adjustment or exception within the system.* We believe these must be carefully con-

sidered so as not to penalize the provider for circumstances beyond its control. On the other hand, they must be limited so as not to destroy prospectivity and the related incentive. Perhaps the most important area in this connection is allowances for new facilities, equipment and services. Our comments on changes in the retrospective cost based system addresses this point in some detail and are equally applicable here.

Other areas that deserve consideration for automatic adjustment and/or exception (determined on an individual case basis) are:

(a) Volume changes (including changes in case mix).

(b) Significant price factor changes in specific elements of cost beyond that anticipated in the projected rate (e.g., malpractice cost; fuel cost)

(c) Compliance with new legislation

(d) Natural catastrophes

Appeals

The prospective system and indeed any payment system must provide for a mechanism that allows the provider to appeal decisions that flow from the system.

The appeal system must provide reasonable access for all providers without undue administrative requirements and must be responsive on a timely basis. No system should limit a provider's right to have a reasonable forum to present its case for an adjustment of the payment rate.

To the extent that the appeal mechanism is distinct from the original decision process, provider confidence in its viability is increased.

We have previously commented on the absolute need for the availability and opportunity to choose from a variety of approaches, and also have indicated that such an approach is administratively feasible. However, there are a number of issues relative to implementation which require comment.

First, we would suggest that initially the efforts in this program be directed toward hospitals. This is appropriate since hospitals account for a significant portion of the total institutional expenditures under Medicare.

Secondly, the Secretary should convene a national panel of experts in the health care field, including representatives of the hospital industry, private third party payers, government, academia and others for the purpose of:

(1) Setting forth standards against which prospective payment programs which apply for Medicare participation would be evaluated for acceptance. In this connection, appropriate criteria might be:

(a) Reasonable cost of administration

(b) Significant portion of hospital revenue impacted by the program (with Medicare included for example, 60%)

(c) Compliance with the 10 design criteria previously outlined

(d) Ability to collect, maintain and report evaluative accounting and statistical data required

(e) Operational capability within a specified period, for example, two years.

(2) Evaluating applications for acceptance or making recommendations to the Secretary regarding an applicant.

In this connection, the evaluations must be sensitive to the Medicare Program's best interests, but at the same time stimulate the development and application of prospective rate programs.

Applicants for an alternative prospective approach will not be able to prove or guarantee the success of their programs before the start.

In considering applications, state rate regulation programs should be considered and evaluated along with all other applicants. While Medicare should participate in state rate programs, the general objectives we have outlined—to try a multiplicity of approaches—should be maintained. State rate regulation should not be the predominant method and various approaches should be considered.

(3) Either the Medicare program or another agency of the federal government should have prime responsibility for financing thorough evaluations of the costs and benefits of all significant prospective or other incentive payment approaches employed currently or in the future.

In this connection, the evaluation should consider the impact of the payment mechanism on:

(*a*) The cost/efficiency of the provider;

(*b*) The capital structure; and

(*c*) Quality of care.

To accomplish this will require collection of basic accounting and statistical data. Such data must be uniformly reported on a timely basis if it is to be useful in these evaluations. This data base could be used to establish health policy and assist in the formulation of appropriate governmental budgets for the Medicare program.

To accomplish this, a system of uniform reporting would be required which would include uniform definition of the accounting base, cost allocation methods and statistical accumulations necessary for the data to be reported.

Specific revisions in Medicare's current retrospective cost-based method

We have previously commented on the need to provide prospective or incentive payment methods which have the potential to serve as an effective cost containment tool. Our comments also indicated that since we believe that the incentive features of the present Medicare payment system have had only minimal impact in that direction, a change in the design of those features was in order.

Revision of the existing cost-based reimbursement method should be designed to provide:

(*a*) strong incentives to stimulate the design and testing of prospective or incentive payment programs; and

(*b*) moderate rates of increase in institutional health care cost.

This would require the establishment of incentive features in the basic cost-based method that are sufficiently "tight" to motivate providers to consider applying for use of prospective and other incentive options, yet not so "tight" as to:

(*a*) work unreasonable hardships or gross inequities on providers using the basic method; and

(*b*) make it unattractive for the Medicare program to develop or accept alternatives to the basic method.

Enactment and adoption of the changes as soon as possible is important to bridge the gap while prospective or incentive programs are being readied to use in Medicare and to further accelerate the pace of their design and acceptance.

A key feature would be revision of the cost containment incentive features in Sections 221, 223 and 251 of Public Law 92-603.

The changes should be designed to provide an effective and reasonable balance in terms of administrative simplicity and efficiency; equitable treatment of individual institutions and the industry as a whole; and demonstrable results and the support and stimulation of more rapid development and use of the more permanent long-term cost containment mechanisms (e.g., health planning, innovative prospective payment methods, utilization review, and alternative delivery systems.)

These changes should relate to the provider as a complete institution, permitting management to determine what alternative courses of action it may pursue and how the results of its decisions may be impacted by the availability of prospective incentive systems. Specific incentives should be incorporated into the methodology which serve to accelerate the design and implementation of specific cost containment measures. Further, incentives should be developed which recognize and reward acceptable cost performance.

The incentives would need to take into account several factors related to the incurrence of cost in the hospital industry. Among these are:

(1) Provider cost incurrence is reflective to some extent of price inflation factors which move faster in the hospital sector than those in the economy as a whole.

(2) Incentive system features can impact on other determinants of total program costs (e.g., on utilization or the shift from inpatient to outpatient services and as such must be carefully integrated into a total cost containment perspective.)

(3) Hospital costs can be generated by factors such as natural catastrophes, which are beyond provider control.

Of the possible areas for providing incentives, the ones concerned with capital expenditures and related operating expenses for new or modified services, facilities and equipment are perhaps the most important. This is particularly true of capital expenditures for bricks and mortar due to their potentially dramatic impact on institutional costs in both the short and long term.

Needless to say, any such incentive feature should be linked to the health planning process. However, the Medicare program should carefully evaluate its current position of support for all health planning agency approved projects. The evaluation should take into account past and current uneven performance of health planning processes; the need for designated planning agencies to do effective health planning without pressure to process applications; and the current cost increase environment.

During this period it may be necessary to establish a more restrictive approach that sets forth realistic criteria to allow only necessary and appropriate growth and/or cost effective modification of the existing hospital industry, while providing a stimulus for improvement of the health planning process provided for under the provisions of Public Law 93–641.

This approach could, for instance, limit allowances for capital payments to only capital projects approved prior to its adoption, on which construction is already underway, or with firm contractual obligations, projects required to maintain compliance with governmental or voluntary agency patient/employee health safety standards; and approved projects directed toward filling "gap" area health care service needs of designated medically underserved populations; and in addition, only those other proposed capital projects approved by a fully-designated SPDA under Public Law 93–641.

Other positive features are needed to bolster support for necessary health care facilities and their appropriate use. One of the most important is the measure introduced by Senator Talmadge that would provide for continued capital payments related to facilities that are closed. We support such a provision and have recommended its expansion for broader application and impact.

Another program which has promise and should be expanded is the "swing bed" experiments being conducted in three areas. These experiments provide for special incentive reimbursement when acute care beds in an underutilized facility are used for long term care patients in areas that have a shortage of long term care facilities.

Conclusions

The above sets of initiatives are complex undertakings, from which we cannot expect immediate results. They must, however, begin as soon as possible.

All elements of the private and public sectors involved in health care financing and delivery must move forward in a consistent and coordinated manner to design, test, adapt and employ—on an increasingly broader basis—prospective or other incentive payment systems and other cost containment programs previously described. As the complex cost problems occur and are felt at the local level, it is local solutions matched against local environments that can produce positive change. There are no simple national solutions. The Medicare program—structured as it is for national level policymaking yet decentralized administration through third party payer intermediaries—is in a prime position to design, test and evaluate local approaches in concert with providers and other payers, and to do so in the context of national objectives.

Motivation and commitment are the key to future success of the various cost containment initiatives. The Medicare hospital reimbursement reforms we are suggesting will not produce perfect results, particularly over the short term. However, the Medicare program must be willing to take risks in designing and testing incentive approaches, aware that some may ultimately prove ineffective, but that many different types need to be tried and compared simultaneously in various regions of the country. The advantages of encouraging flexibility and innovative management are critical during this period of time when there is no single simple solution to the reimbursement problem and in our judgment would represent enlightened public policy.

In the final analysis, incentive payment systems and other cost containment tools are merely approaches. Whether their potential is realized depends upon the commitment of both providers and payers to make them work. The experience to date with the 1972 Social Security Act amendments is a prime example of basically good ideas which do not guarantee good results. This situation must dramatically improve. An important facet of the initiatives we have suggested here is the need to focus more on the end-results of providers' performance than on their processes, giving managers incentives to manage their resources wisely, but leaving them the flexibility to decide how best to do that within a broad-based incentive system.

Once again, I thank you for letting me give this lengthy presentation of our views on an extremely complex subject.

Mr. Rostenkowski. Thank you, Mr. Hollander.

Mr. Cotter will inquire.

Mr. Cotter. Thank you very much, Mr. Hollander.

We have heard this discussion about prospective and retrospective reimbursement. Do you really feel there is nothing wrong with the retrospective approach?

Mr. Hollander. My answer to that would be, it all depends, Mr. Cotter. I think the critical issue, as I outlined in my testimony, is not whether the system is retrospective or prospective. It is, rather, whether it contains those incentives which bring about good cost-effective management of health care services. As a matter of fact, most of the prospective approaches that are being tested today, because they allow for changes in reimbursement based upon legitimized activities in effect become highly retrospective because the costs incurred need to be settled at the end of the year.

I think the important question is whether the payment—regardless of its prospective or retrospective nature—is providing incentives for hospitals to operate in a more efficient manner.

Mr. Cotter. What disturbs me about a retrospective approach is that a hospital will conduct its operations during the course of the year and at the end of the year they send Blue Cross their bill. It does not appear to be the proper approach. In the prospective approach, they are given a certain amount of money, and they are asked or told to live within it. It seems there would be a deterrent there.

Mr. Hollander. I would agree with you in a situation where a hospital merely sends a bill to a third party payer, the Blue Cross, the Government, or anyone else for that matter, without anyone being concerned about the incentives behind that payment. It would be important to build into a retrospective system protection against overpayment and incentives for good performance.

If, at the end of the year, for example, a particular hospital performed better than other hospitals in a like peer group, it might be paid an incentive payment which, incidentally might be shared with these people in the hospital that brought about that good management results.

As a manager before the beginning of each year, I plan prospectively, but I receive costs and final summing up retrospectively at the end of the year. I hope, at least, that I manage on a prospective basis whatever system I am using in planning for expenses and bringing about efficiencies.

Mr. Cotter. What concerns me, and I am not familiar with it at the present time, but I notice 5 or 6 years ago, in the State of Connecticut, the board of Blue Cross was composed, a majority of them, of hospital administrators.

How can the public expect to get a fair shake when the people running Blue Cross programs are the hospital administrators themselves. They are not necessarily interested in curtailing the amount of money which they will receive, or to collect costs or expenses?

Mr. Hollander. In the past, Mr. Cotter, it may have been true that there was an overrepresentation of hospital administrators on Blue Cross boards. That has changed. It was pretty much related to the historical origins of Blue Cross. If this committee would be interested, I would be happy to submit the figures on current Blue Cross board membership, and I think it would demonstrate that Blue Cross boards are no longer dominated by hospital administrators.

Mr. COTTER. Without objection, Mr. Chairman.

Mr. ROSTENKOWSKI. It is so ordered.

[The information follows:]

As of January 1, 1976, there were 1,823 Blue Cross Plan board members. Of these, 1,222 or 67 percent are public representatives; 323 (18 percent) are hospital representatives, and 278 (15 percent) are medical representatives. Of the 1,222 public representatives, 131 (6 percent of the total number of board members), also serve as trustees on hospital boards.

Mr. ROSTENKOWSKI. Mr. Duncan?

Mr. DUNCAN. No questions, Mr. Chairman. Thank you.

Mr. ROSTENKOWSKI. Mr. Burleson?

Mr. BURLESON. Thank you, Mr. Chairman. No questions.

Mr. ROSTENKOWSKI. Thank you, Mr. Hollander.

[The following was subsequently received for the record:]

BLUE CROSS ASSOCIATION,
Chicago, Ill., September 10, 1976.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, Longworth House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: At the August 3rd Ways and Means Health Subcommittee hearing on Medicare hospital reimbursement, part of my testimony discussed the design, testing and evaluation of incentive payment systems—both retrospective and prospective.

After the hearing I got the impression that the subcommittee misunderstood the intent of my comments and concluded that I (speaking for the Blue Cross Association) specifically supported retrospective in preference to prospective payments. I would like to clarify the Association's stand on this issue.

Our feeling is that the important objective is for Medicare to provide incentives to hospitals to perform well—efficiently, effectively and economically. Those incentives can be either of two kinds: positive (e.g., an actual financial reward for good performance, particularly in comparison with its peer group) or negative (penalties for poor performance, such as non-payment for expanded services or for services provided in new facilities not approved by the appropriate planning agency).

We believe that effective incentives can be provided either through prospective or retrospective payment mechanisms. There is no inherent magic in a particular type of payment system. Neither prospective nor retrospective payment method, as far as we can see, are entirely good or bad. Both can be effective, but only if properly designed and managed. With that in mind, we believe that Medicare's focus should be on achieving the desired results rather than supporting or opposing a particular method of getting them.

Perhaps the biggest disadvantage of the retrospective method which has been characteristic of Medicare so far is that it tends to pay the hospital its costs, whatever they might have been and thus provides no real incentive for cost-concious management. PL92–603 sought to affect that situation by imposing certain penalties: e.g., Section 221, which ties expansion to planning decisions; Section 223, which limits coverage of Medicare costs; Section 233, which determines the amount of payment where customary charges for services are less than reasonable costs; and Section 251, covering physical and other therapy services. There is, however, no real evidence that those provisions have yet had a positive effect on either Medicare reimbursement to hospitals or the hospitals' performance. Nor is there any way to really tell whether the current Medicare retrospective payment method is more or less inflationary than any other existing or potential method.

An important characteristic of the prospective reimbursement methods currently in use is that they allow for adjustments at the end of the provider's fiscal year for events beyond the provider's control: unexpected increases in over-all inflation (higher fuel bills, for example); changes in patient mix; or increases in expected volume of services required. Those adjustments pretty well have to be built into prospective methods to avoid real hardships on providers. But, the more adjustments allowed, the more the prospective method becomes, in effect, a retrospective one with a settlement after the fact. Conversely, if the provider knew at the beginning of a year what, clearly defined limits of reasonableness would be applied to its reimbursement at the end of a year, a retrospective incentives system would take on a significant element of prospectivity.

The difference between the two methods is not the fact that rewards or incentives can be built into one and not into the other. Either may provide all of the rewards and incentives necessary to encourage good performance.

Most of the non-Medicare prospective payment systems and experiments now underway have been promoted and implemented by Blue Cross Plans. While we have encouraged the development of prospective payment methods, at the same time, we have not suggested abandoning retrospective systems, particularly since they are in place now. What we want to see are increased efforts to put incentives into the present system and more tests and experiments of both methods to find those that will produce the desired results.

I hope that this letter clarifies our position. If I can be of any further help, or provide any additional information, please let me know.

Sincerely,

Neil Hollander,
Vice President, Health Care Services.

Mr. Rostenkowski. Mr. Womer, welcome to the committee. Would you identify yourself, and proceed with your testimony?

STATEMENT OF CHARLES B. WOMER, CHAIRMAN, COUNCIL ON TEACHING HOSPITALS, PRESIDENT, YALE-NEW HAVEN HOSPITAL; ON BEHALF OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY RICHARD KNAPP

Mr. Womer. I am Charles Womer, chairman of the Council of Teaching Hospitals of the Association of American Medical Colleges and president of Yale-New Haven Hospital, New Haven, Conn.

This morning, I am accompanied by Richard Knapp, Ph. D., director of the association's department of teaching hospitals.

The Association of American Medical Colleges is pleased to have this opportunity to testify on rising hospital costs and possible revisions in the medicare reimbursement program. The association represents 400 of the Nation's major teaching hospitals, all of the Nation's medical schools, and 60 academic societies. Thus, revisions in the medicare reimbursement program are of direct interest and concern to the association's members.

I have submitted a detailed statement of the association's position on hospital increases and reimbursement alternatives for the subcommittee's consideration, and for inclusion in the record of the hearing. In the written statement, the association discussed factors that contribute to hospital cost increases. Because that discussion is of necessity quite general, it seems to me that the most effective contribution I can make during my testimony this morning is to provide an illustration of the dimensions and reasons for hospital cost increases using, as an example, the institution which I serve as chief executive officer.

I will begin the statement with a brief description of Yale-New Haven and its cost increases from fiscal year 1976 to 1977. This is not to suggest that the hospital is representative of all teaching hospitals, or is it to suggest that the hospital is totally atypical. Rather, it is an attempt to help insure that a discussion of reimbursement alternatives is undertaken with an appreciation for the situation of the individual provider who serves program beneficiaries.

Yale-New Haven Hospital has a major affiliation agreement with the Yale University School of Medicine. The hospital's budget for the fiscal year 1977, which begins this coming October 1, has been carefully reviewed and approved by its board of directors and currently is being reviewed by the Connecticut Commission on Hospitals and Health Care. The budget includes an increase in net operating expense of $9.9 million, or 14.2 percent. It also includes a projected revenue increase of $9.5 million, or 13.6 percent.

As the purchasers of goods and services from the general economy, hospitals reflect the price increases in the general economy. At Yale-New Haven, 36 percent of the budget increase results from price increases in purchased goods, services, and insurance. From direct inquiries with vendors and from surveys conducted by the Connecticut Hospital Association, hospital supplies at Yale-New Haven are expected to cost it $1.3 million more this year than they did last year. In addition, it is estimated that insurance coverage, including malpractice insurance, will increase by almost $900,000 during the next fiscal year—this is in addition to a similar increase during the current fiscal year.

In addition to purchasing goods and services from the economy, we are a major purchaser of labor. To attract and retain qualified employees, the hospital's wage scales must remain competitive; 28 percent of the hospital's budget increase will go for wage and salary increases. Given the rate of inflation present in the economy, I do not consider a 5-percent general wage increase unwarranted or excessive.

Combining the increases for goods and services with the wage and salary increases, inflation has a heavy impact. Over 64 percent of the budgeted increase at Yale-New Haven results from increases in prices for goods and services and wages and salaries. As long as prices and wages in the general economy increase as they have, an increase of this magnitude is virtually unavoidable by the hospital unless current services are to be reduced.

In addition to inflationary increases beyond the hospital's control, a $630,000 increase in expenditures is also uncontrollable, for it is the amount the hospital must spend this year to revise its pension plan in order to meet federally mandated pension requirements. I am not arguing that these pension plan improvements are unnecessary or undesirable. I am only trying to point out 6.4 percent of the budget increase at Yale-New Haven will be due to them.

In addition to more adequately supporting the population served by the hospital, $1.7 million is budgeted for maintaining improved services and for adding new hospital services. This includes new patient care personnel, an expanded house staff and increased expenditures in special services departments. Certainly this 17.5 percent of the budget increase is controllable by the institution. It represents expenses that could be avoided if the services were not offered. However, in the opinion of the board of directors and the medical staff and with the concurrence of planning authorities where appropriate, these additions are necessary for the hospital to fulfill its responsibilities as a tertiary care referral service as well as a community hospital.

A $9.9 million or 14.2-percent increase in operating expenditures is significant. I would hope, however, the subcommittee will appreciate the dilemma faced by a hospital trying to contain its costs. Over 70 percent of the increase is not really under my control or that of the board of directors. Prices for goods, services, and wages are determined by the general economy and federally mandated pension and other standards which must be met.

Above this 70-percent uncontrollable increase, almost two-thirds of the remaining increase is for the improved and expanded services required to adequately support the population served by the hospital.

I should point out Yale-New Haven is participating in a number of cost-containment activities. It has a joint committee of trustees with the other hospital in New Haven which retained a respected consulting service to study the two hospitals' programs in therapeutic radiology, open heart surgery, obstetrics, pediatrics, and chronic dialysis. It participates in an extensive group purchasing and a cooperative laundry with four other hospitals. Its department heads administrative staff are required to submit semi-annual reports on their cost-containment activities.

These measures play a major part in the annual evaluation of their effectiveness. Its financial controls are sophisticated and effective. The foregoing are but examples of a number of cost containment activities which have been undertaken.

Moving beyond the specifics of the situation at the individual hospital, it should be recognized that increases in hospital costs are the result of six contributing factors: General economic inflation, Government-mandated programs, new services, benefits and technologies, changes in population size and composition, per capita utilization of services and some excesses and duplication in our Nation's increasingly complex health care system. Further aggravating the increase in hospital costs is the fact that there is a number of inconsistent, and sometimes contradictory national policies for the health care industry.

For instance, some seek to increase the number of physicians, but the result most likely will be contrary to the intent of others who advocate cost reduction or containment.

Just compensation for patients with adverse clinical outcomes is sought, while large awards increase malpractice premiums and stimulate defensive medicine.

Excess beds and staff are condemned while hospital closures are prevented by public opposition seeking, in part, to retain full employment.

Certification and licensure of health occupations is advanced while overspecialization and its cost are attacked.

Biomedical researchers are encouraged to strive for breakthroughs providing completed technologies and chastised for not actively and immediately applying each partial finding.

Primary and ambulatory care are encouraged while funding increases are more readily obtained for catastrophic and terminal care.

Excellence as a standard of care is to be attained, but costs are to be minimized.

These six factors contributing to costs and the presence of inconsistent and contradictory policies have generated and sustained rising health care and hospital costs.

While the association is ever mindful of the growing consensus that continued rapid increases in the unit cost of health care are unacceptable and cannot continue, we are also appreciative of the administrative difficulties of achieving cost containment through increasingly complex reimbursement practices. As Dr. Alice Rivlin has stated in her May 17, 1976 testimony before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, "It is clear that the development of financial incentives and disincentives which can restrain inflation and wasteful expenditures without at the same time curtailing desirable improvements in quality of health services, and imposing rigidities on the delivery system will be a sensitive and difficult task."

The association is opposed to any program which restricts reimbursements by imposing an arbitrary percentage cap. While this approach does contain reimbursement expenditures, an arbitrary expenditure cap has substantial deficiencies and inequities. It fails to recognize or account for regional and institutional variations in uncontrollable costs. It can unduly benefit providers with a high proportion of fixed costs. It has a relatively punitive effect on the already efficient providers. It penalizes providers whose costs have been held down by State rate review. It places an unusually heavy burden on teaching hospitals, which introduce the costly technologies and accept the referrals of high-cost patients, and referrals of such patients tend to increase when costs are arbitrarily controlled. It can threaten the access of program beneficiaries to needed services by undermining the program viability of providers.

A longer term approach is based on reimbursement limitations derived from cross-classification schemes which are carefully drawn and conscientiously implemented. Their usefulness in eliminating inefficiency is enhanced by assuring comparable costs are being examined and controlled. The association supports the exclusion from routine operating costs in H.R. 13080 of capital costs; direct personnel and supply costs of hospital education and training programs; costs of interns, residents and medical personnel; and energy costs associated with heating or cooling the hospital plant. The association would recommend, however, that the malpractice insurance premiums and energy costs of lighting and facility operations be similarly excluded and that the wage rate adjustment reflect regional costs for technical and professional personnel.

The association believes three provisions of H.R. 13080 are excessively rigid. First, given the lack of available data to analyze the proposed classification scheme, the Association recommends that H.R. 13080 state that hospitals will be classified by type and size, that explicit guidance of congressional intent be provided in the committee report, and that a national technical advisory board be appointed to evaluate and research alternative schemes and groupings.

Second, giving the absence of data to evaluate the impact over a separate category for the "primary affiliates of accredited medical schools" and given the unrealistic limitation of this category to one hospital per medical school, the association strongly recommends more flexible legislation directing the Secretary of HEW to examine the implications of alternative definitions of the term "teaching tertiary care hospitals."

Last, because the present medicare reporting system is unable to provide adequate data to evaluate the impact of establishing the reimbursement ceiling at 120 percent of a group's cost ceiling, the association recommends providing the Secretary of HEW with authority to establish the ceiling in accordance with congressional guidelines stated in the committee report. While the association finds section 10 of H.R. 13080, with suggested amendments, worthy of support, the association recommends that we move forward cautiously and under the review and supervision of the above recommended advisory board.

[The prepared statement follows:]

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges is pleased to have this opportunity to testify on rising hospital costs and possible revisions in the Medicare reimbursement program. The Association represents 400 of the nation's major teaching hospitals, all of the nation's medical schools, and 60 academic societies. Thus, revisions in the Medicare reimbursement program are of direct interest and concern to the Association's members.

For ease and clarity of presentation, this testimony is presented in three major sections. It begins with a discussion of background issues considering factors which contribute to health expenditure increases and describing the dilemma of a service industry facing contradictory public policies. Secondly, it briefly describes the appropriate role reimbursement should have in cost containment. Lastly, this testimony addresses short-term and intermediate reimbursement alternatives for containing costs.

BACKGROUND ISSUES

For the past three decades, our nation has experienced an unprecedented increase in health expeditures. While there is a continuing debate on the percentage of national economic expenditures which should be devoted to health care, there appears to be a growing consensus that the present rate of increase in the unit cost of health services is unacceptable as a long-run proposition. As an Association of providers and practitioners who would like to share in efforts to contain health care costs, the AAMC is obligated to first consider the background issues which have generated and sustained rising health care and hospital costs.

Factors contributing to hospital cost increases

Hospital costs are the end result of the actions and interactions of six contributing factors. First, general economic inflation adds to health costs. Hospitals purchase goods and services from our inflationary economy, and increases in these factor prices must be added to hospital costs. Purchasing liability insurance, electricity and fuels, food, medical supplies and personnel from the general economy, the hospital shares the inflation ascalator with the larger society.

Second, in an effort to improve the quality of life, governments at all levels have mandated programs which increase hospital operating costs. Pension reform, occupational health and safety, life safety requirements, and pollution control programs are all desirable. But, each adds new costs to the hospital without adding additional health services.

Third, new services, benefits, and technologies are constantly being added. While some new services—such as the polio vaccines and some pharmaceutical products—have provided substitutes for more expensive treatments, many others have complemented and expanded previous hospital services and costs.

Fourth, the American population has undergone significant changes in its size and composition. Increasing numbers of the aged continue to present chronic and degenerative health problems requiring extensive and continuing treatments. Increasingly, families use the hospital for services previously provided by the extended family. Home care, social services, and the various therapy specialties provide legitimate programs supporting the population, but each increases hospital costs.

Fifth, per capita utilization of services has increased with health insurance coverage, rising levels of socioeconomic status and educational attainment, and urbanization. In addition to simply increasing the number of services used, these factors have shifted utilization toward the more sophisticated and specialized services which are produced at higher costs.

Sixth and finally, the health care system does not function at peak possible efficiency. This is *not* to assert that vast amounts of intentional inefficiency and duplication are present. Rather, it is to honestly acknowledge that the increasing complex health care system of our nation develops some excesses and duplication that adds to hospital costs. To varying degrees, this same phenomenon occurs in every industry, for it is impossible to construct any system or machine that is one-hundred percent efficient.

These six factors, in an integrated and complex fashion contribute to increasing hospital costs. Further aggravating the situation is the fact that there are a number of inconsistent and sometimes contradictory national policies and priorities which need to be understood and highlighted.

Contradictory policies for a service industry

Health care providers and practitioners are critical elements of a service industry which exists to meet the legitimate needs of the population. At the present time, however, clear and consistent policies and priorities for this industry do not exist. Contradictory policies are abundant.

Some seek to increase the number of physicians, but the consequences are most likely contrary to the intent of others who advocate cost reduction or containment.

Just compensation for patients with adverse clinical outcomes is sought, while large awards increase malpractice premiums and stimulate defensive medicine.

"Excess" beds and staff are condemned while hospital closures are prevented by public opposition seeking, in part, to retain full employment.

Certification and licensure of health occupations is advanced while overspecialization and its cost are attacked.

Biomedical researchers are encouraged to strive for breakthroughs providing "completed technologies" and chastized for not actively and immediately applying each partial finding.

Primary and ambulatory care are encouraged while funding increases are more readily obtained for catastrophic and terminal care.

Excellent as a standard of care is to be attained but costs are to be minimized.

Many more examples of contradictory health services policies exist, and attempts to fulfill each of them adds to health costs. To contain hospital costs, the Association believes a clearer and more consistent definition of service expectations and policies is needed.

REIMBURSEMENT'S ROLE IN COST CONTAINMENT

Reimbursement practices can have a limited, though valuable, impact on efforts to contain hospital costs. Reimbursement practices have little or no impact on three of the factors contributing to cost increase: costs arising from general economy inflation, government-mandated quality-of-life programs, and population size and composition. Reimbursement practices should have the most limited of roles in resolving contradictory service expectations and policies faced by providers. That is, reimbursement policies should support and sustain public policies—not determine them.

Reimbursement practices can affect the availability of services, per capita utilization, and system efficiency. In the opinion of the Association it would be inappropriate public policy to use reimbursement practices to make policy decisions on service availability and utilization. The health planning and peer review mechanisms passed by the Congress provide a more rational means for determining program policy. Reimbursement should support these program policies—not determine them.

Reimbursement practices, carefully designed and conscientiously applied, can help to stimulate a more efficient health service industry. Constructing such reimbursement practices is not an easy task. As Dr. Alice Rivlin has stated in her May 17, 1976, testimony before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, "It is clear that the development of financial incentives and disincentives which can restrain inflation and wasteful expenditures without at the same time curtailing desirable improvements in quality of health services, and imposing rigidities on the delivery system will be a sensitive and difficult task."

REIMBURSEMENT ALTERNATIVES

One alternative for changing Medicare reimbursement is the establishment of an arbitrary percentage cap on expenditure increases. Without doubt this approach does contain reimbursement expenditures; however, it has several deficiencies and inequities as a means of containing costs. First, it fails to recognize or account for regional and institutional variation in uncontrollable costs or in needs for improvement. Malpractice premium and energy price differences are ignored. Changes in patient mix disregarded. Differences in local labor situations are omitted from consideration. Increases and decreases in the volume of services are not recognized.

Second, an arbitrary percentage cap unduly benefits those providers with a high proportion of costs that are fixed. Hospitals with large capital costs—interest and depreciation—and fixed pension obligations are able to use the percentage increase applied to this constant base to fund variable expenses.

Third, an arbitrary percentage cap has a relatively punitive effect on the already efficient providers. The inefficient provider is able to use funds from both the percentage increase and from gains in efficiency to support uncontrollable expenditures, new programs, and increased utilization. The already efficient provider cannot draw funds from previous inefficiencies to support cost increases which exceed the percentage cap. Thus, an arbitrary percentage cap can threaten the financial integrity of the efficient provider more than it threatens the financial integrity of the inefficient provider. Indeed, this would be a perverse incentive and reward system.

Fourth, an arbitrary percentage cap penalizes providers whose costs have been held down by voluntary or compulsory state rate review. Having been allowed smaller expenditure increases in the past, providers in cost-controlled states have a smaller base against which to apply the percentage increase.

Last, an arbitrary percentage cap places an unusually heavy burden on teaching hospitals. Teaching hospitals frequently introduce and evaluate newly developed technologies, techniques, and services. Such innovations naturally include relatively high costs because the services operate at less than full capacity. An arbitrary percentage cap threatens the teaching hospitals' financial ability to continue this service for our nation. Moreover, because the teaching hospital is the referral point for sophisticated and costly services, less sophisticated hospitals faced with financial difficulty may increase the referral of their most costly patients to the teaching hospital in order to reduce their financial problems. Thus, an arbitrary percentage cap leads to a disproportional increase in the costs of teaching hospitals.

For all of these reasons, the Association is opposed to any program which restricts reimbursements by imposing an arbitrary percentage cap.

Another alternative is the establishment of reimbursement limitations derived from cross-classification schemes skillfully constructed and thoughtfully employed. The bill introduced by Representative Duncan, H.R. 13080, if appropriately amended, provides a framework for advancing such an approach beyond the limitations presently resulting from Section 223 of P.L. 92–603. Therefore, the balance of this testimony will address Section 10 of H.R. 13080.

H.R. 13080: Uniform accounts, cost reporting, and allocation procedures

The most important prerequisite for proper evaluation and measurement of "routine operating costs" is the development of a system of uniform cost reporting which assures the comparability of financial data. Experiences in such states as California and Maryland, where uniform financial reporting systems are being developed and implemented, demonstrate that, with the present "state-of-the-art" in this area, enormous efforts are required to attain the goal. Similarly, Federal efforts to develop uniform accounting and reporting programs, which are being developed as specified in Section 1533(d) of P.L. 93–641, provide evidence of the difficulties in this area. In considering this bill, the Association urges the Subcommittee to provide an adequate and phased-in period of implementation for uniform cost reporting subsequent to final passage of the legislation.

H.R. 1380: Classification of hospitals

A fundamental concern of the Association is that the designation of specific hospital groups, and other matters, is fixed in the legislation. This eliminates much needed flexibility. Alterations based on experience will be most difficult to make on a timely basis. Recognizing that there is a lack of data available for analyzing the impact of this system, a more prudent approach would be to permit the agencies some flexibility with which to construct the system. At the same time, there are equally pertinent concerns with the extent to which Congressional intent is reflected in Executive Branch implementation. It is, thus, important that the Committee provide the Department with some specific guidelines and direction by which to proceed. Therefore, the Association recommends that H.R. 13080 state that hospitals "be classified by type and size" with some guidance in the Committee Report, rather than stipulate the specific bed categories and types of hospitals. It is further recommended that a "National Technical Advisory Board" be appointed to recommend and evaluate alternative classification systems of size and type, review progress, monitor implementation, examine problems encountered and make recommendations regarding appropriate solutions. The advisory board to be established should include representatives from the Legislative and Executive Branches of Government, as well as knowledgeable individuals from the private sector.

The legislation provides for the creation of a separate group of hospitals which are the "primary affiliates of accredited medical schools." It is difficult to evaluate the implications of creating such a group because of the absence of data. Efforts to gain data and experience with a separate group are hampered by the inability of the current Medicare reporting process to identify and extract the elements to be excluded from the proposed scheme. Thus, there is uncertainty as to the relative merits of a separate group for teaching hospitals.

More importantly, the present legislation would restrict the "primary affiliates of accredited medical schools" to a single hospital per medical school. This is a gross injustice to many teaching hospitals. Limiting each medical school to one and only one "primary affiliate" is arbitrary and does not recognize the complexity or the reality of medical education in this nation. Therefore, the Association opposes the establishment of a specific classification for "primary affiliates of accredited medical schools" as proposed in H.R. 13080.

In the absence of adequate data and operational experience to evaluate the proposed classification scheme and to avoid arbitrarily limiting the "primary affiliates of accredited medical schools" to one hospital per school, the Association is of the opinion that the combination of a flexible classification system and an adequate phase-in period are essential elements of the program's chances for success. Thus, the Association strongly recommends that the Secretary of the Department of Health, Education and Welfare be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals." Instead of prescribing a pre-defined grouping for teaching hospitals, it is proposed that the Secretary be required to determine, in consultation with the appropriate knowledgeable health organizations, a definition which most accurately reflects the teaching hospital's role as a referral center for tertiary patient care services and as an educational institution. In performing these consultations, the Secretary should be required to distribute and share the data upon which alternative definitions are to be evaluated. This is a good example of an issue which would be brought before the above proposed Technical Advisory Board.

H.R. 13080: Determining routine operating costs

If a cross-classification approach is to be used for reimbursement limitation, the Association has recommended the exclusion of specific components of routine operating costs which will help ensure that variations in the remaining costs are not due to the nature of the product produced or to characteristics of the production process. Therefore, the Association believes that the exclusion in H.R. 13080 of capital costs; direct personnel and supply costs of hospital education and training programs; costs of interns, residents, and medical personnel; and energy costs associated with heating or cooling the hospital plant is a step in the proper direction.

The Association recommends that two additional components of routine operating costs be excluded. H.R. 13080 does propose removing "energy costs associated with heating or cooling the hospital plant." This is appropriate and desirable; however, it ignores the energy costs associated with lighting and operating the hospital facility. Prices for these energy costs, like those for heating and cooling, are beyond the hospital's control. Therefore, the Association requests that energy costs for lighting and facility operations also be excluded from routine operating costs which are contained in the proposal. Moreover, because there is wide regional and institutional variation in premium rates, and because these rates are largely beyond the control of the hospital, the Association strongly recommends that malpractice insurance premiums be added to the list of exclusions from routine service costs. The exclusion of the additional energy costs and malpractice insurance premiums will help to ensure the remaining costs are comparable between facilities.

In determining routine operating costs, the proposed legislation includes a provision allowing for initial consideration of hospital wage levels, if available, for the local or state area where they are higher than the general wage levels in the area. Following this initial first year adjustment, future hospital increases would be controlled by increases for all wages in the area in which the hospital is located. While we do recognize some technical problems with these index computations, the Association believes that the general principle is one which should be supported.

A further consideration in the wage level methodology, however, relates to the particular nature of the tertiary care/teaching hospital staffing patterns. The type and array of skilled personnel utilized in academic medical centers is frequently drawn from a regional or national labor pool. For example, the University of Virginia Medical Center in Charlottesville is located in a rural area of the state and outside of an SMSA. It must, however, compete with medical centers in Richmond, Va.; Washington, D.C.; and Baltimore, Md., for skilled personnel. Because many medical centers must recruit personnel outside of the immediate area and across state lines, the Association recommends that the legislation include a provision which recognizes the skilled labor requirements of large academic medical centers.

Following a rather complicated calculation, H.R. 13080 establishes the ceiling for routine service costs at 120 percent of each classification group's average. As we have stated earlier, the present Medicare reporting system does not permit identification of costs to be excluded in computing routine service costs. Therefore, no one knows what the actual distribution of hospital costs by group will look like. The Association believes that a 120 percent ceiling should not be established by statute without knowledge of these distributions. It is recommended that the bill provide the agencies with some flexibility in determining the ceiling and that the Committee Report clearly state Congressional intent as guidance for Executive Branch action.

Section 223 of P.L. 92–603 permitted a provider, with appropriate public notice as determined by the Secretary to charge the patient for "* * * services which are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services * * *" H.R. 13080, in replacing Section 223 does not contain this or a similar provision. Providing that consumers adn medical practitioners are appropriately apprised of additional charges prior to the use of services, the Association recommends that hospitals be permitted to charge the patient above the established cost ceiling for more expensive services directly requested or authorized by the patient.

H.R. 13080 will allow those institutions with routine operating costs below the average for their group to share in the "surplus." One concern that must be raised is the manner in which hospitals will be required to handle this "surplus." Although the Association believes it may very well be inappropriate to stipulate in legislation the specific ways this money must be utilized, Congress is encouraged to provide some guidance while assuring that the institutions have flexibility in determining institutional priorites.

The Association strongly supports the case mix provision provided in H.R. 13080. Tertiary care/referral hospitals serve the more severely ill patients and referral of such patients from other hospitals tends to increase in times of adverse economic conditions. Recognition of these facts in the legislation should help to ensure the economic integrity of tertiary/referral centers.

Experience gained since the development and initial operation of Section 223 of the 1972 Medicare amendments has demonstrated the urgent need for a viable and timely exception and appeal process. Such an effective and equitable process has not functioned under the present Section 223 cost limitations. Therefore, the Association recommends this legislation include provisions for an exception and appeal process which provides (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties; and (4) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no reduction in the per-admission costs.

The present bill provides for the Secretary to notify the hospital of its adjusted per diem payment rate for routine operating costs no later than April first of a given year. A hospital finding that its projected costs exceed the ceiling will presumably attempt to lower its costs. To lower its costs, the hospital may have to reduce its labor force or terminate existing contracts. Employee reductions and contract alterations not only require careful planning, they frequently require significant advance notification. Because many hospitals have fiscal year and reporting periods beginning on July first, H.R. 13080 would provide only a ninety day notice on the ceilings. The Association recommends that the bill be changed to require at least a 120 day notification by requiring the Secretary to notify the hospitals of their routine operating cost ceiling no later than March first of a given year.

Section 10(e) provides that "nothing in this section shall be construed as otherwise limiting the authority of the Secretary to continue otherwise authorized efforts toward development of improved systems of reimbursement * * *" The Association recommends that this subsection be modified to strongly and positively encourage the Secretary to continue and, where appropriate, expand efforts to develop improved systems of reimbursement.

Assuring Medicare beneficiaries' needed health care services, encouraging efficiency in the provision of health care and paying the full and fair costs of health care providers should be the guiding principles of any reimbursement system. The compatibility of the goals can be maintained under a system which accounts for the many legitimate service and case mix differences found between hospitals. When this is done, illegitimate costs arising from inefficiency or extravagance can be isolated. However, if care is not taken to identify the costs of inefficiency, legitimate reimbursement may be threatened and consequently the hospitals' ability to provide needed health services.

While the Association finds H.R. 13080 with suggested amendments, worthy of support, the Association recommends that we move forward cautiously and under the review and supervision of the above recommended Technical Advisory Board.

CONCLUSION

The Association expresses its appreciation to the Committee for this opportunity to testify on rising hospital costs and reimbursement alternatives for containing hospital costs. The Association shares the Committee's objectives of improving the Medicare program and containing its costs.

Mr. ROSTENKOWSKI. Thank you.

Mr. Waggonner.

Mr. WAGGONNER. You are representing the Association of American Medical Colleges. One of the factors that has led to the increased medical care costs is the "contrived shortage" of physicians and representatives of the American Medical Association. Would you agree, or disagree, that there is a "contrived shortage" of physicians?

Mr. WOMER. I would have to question the word "contrived." I think there is definitely a shortage of physicians in many areas of the country. There is also a surplus in other areas of the country. There is a shortage of some physicians in some specialties, and there is a surplus of physicians in other specialties.

I think the association is concerned that we are continuing to increase the number of medical students in the medical colleges without knowing what the end result of past increases is going to be. I think 10 years ago in this country, 7,500 students were admitted to medical school. This year, 15,000 or more students were admitted to medical school.

Now the medical education process, including both medical school and postgraduate education, means that it usually takes at least 6 or 7 years between the time a student is admitted to school and the time he is out in practice. We are concerned, quite frankly, that we will overshoot medical school admissions and not notice it until several years later.

Mr. Waggonner. What you are saying, really, then, is that there is not so much a shortage as there is a distributional problem with regard to doctors?

Mr. Womer. I think there is a shortage in some areas. I think the major problem is specialty and geographic maldistribution.

Mr. Waggonner. I guess you have heard enough about malpractice that that would be it for the day.

You listed some factors which have contributed to increased hospital costs. I notice that you did not list the increased cost which is an ever-increasing proposition of complying with Government rules, regulations and that sort of thing.

Mr. Womer. It definitely is a factor. At the institution which I represent, I can say that our legal costs, for instance, have more than doubled in the last 4 years for analyzing ERISSA, matters before the Connecticut Commission on Health Care, interpreting regulations and interpreting court decisions. Also, internally we have added significant numbers of people to our accounting departments, these costs are significant, although I did not mention them because in the totality of the hospitals' total budget, they are relatively small. I would have to say our major cost increases were in the other area.

In other words, this coming year's increase in malpractice insurance premiums, for instance, probably outstrips the increase in our accounting department of the last 10 years.

Mr. Waggonner. Thank you, Mr. Chairman.

Mr. Rostenkowski. Mr. Duncan will inquire.

Mr. Duncan. No questions, Mr. Chairman.

Mr. Rostenkowski. Mr. Cotter?

Mr. Cotter. No questions.

Mr. Rostenkowski. Thank you, Mr. Womer.

Mr. Borsodi, would you identify yourself and provide us with your testimony?

STATEMENTS OF PANEL FOR AMERICAN ASSOCIATION OF RETIRED PERSONS AND NATIONAL RETIRED TEACHERS ASSOCIATION, CONSISTING OF RALPH BORSODI, CONSULTANT; LAURENCE F. LANE, LEGISLATIVE STAFF MEMBER; AND JAMES M. HACKING, LEGISLATIVE STAFF MEMBER

Mr. Borsodi. Thank you, Mr. Chairman. I am Ralph Borsodi, a retired economist and consultant to the National Retired Teachers Association and the American Association of Retired Persons. These affiliated organizations have a combined membership of over 9.5 million older persons.

With me today are Laurence Lane and James Hacking, members of the association's legislative staff.

We are responding to the subcommittee's request for comment on given issues under the medicare programs, and specifically on your topic No. 9. Our associations endorse annually determined ceilings on hospital cost increases. We propose that medicare not recognize hospital costs as reasonable, unless the costs are within these ceilings. We propose that these ceilings continue until an effective prospective payment system is installed to assume the function of rate setting. We do not, however, think that medicare problems can be treated in isolation. To avoid discrimination against medicare beneficiaries and a shift of the financial burden to nonmedicare hospital inpatients, the ceilings must be applied to all hospitals, and all third-party payors must observe them.

THE PROBLEM: CHRONIC INFLATION

Over the period 1965 to 1975, health expenditures increased from 5.9 percent to 8.3 percent of GNP, an increase of 41 percent. The 1974–75 increase of $14.5 billion was the largest ever.

Price increases for medical services over the last decade have significantly outpaced increases in other service prices. The medical care services component of the CPI rose 10.3 percent in 1975, with hospital service charges rising by 13 percent and physician fees by 11.8 percent. In contrast, the CPI's overall service component—less medical services—rose only 7.7 percent. It is clear to us that forces within the health sector are driving medical service prices widely out of line.

We are deeply disturbed that the forecasts for health service prices call for more of the same. Forecasts of price inflation rates for the current year fall between 5 and 6 percent. But contrast these predicted general inflation rates for goods and services with the inflation expected in the hospital costs. The trustees of the Federal hospital insurance trust fund expect hospital inpatient costs in the aggregate to rise by 15.9 percent during 1976. They foresee no appreciable moderation in these annual rates of increase for years to come.

THE CONSEQUENCES OF THIS INFLATIONARY TREND

For the hospital insurance program, the consequences are serious. The ratio of expenditures to taxable payroll has increased from 0.95 percent in 1967 to an estimated 1.73 percent in 1975. Further increases in this ratio to 2.26 percent in 1980 and 4.93 percent in the year 2000 result from an assumed continuation of increases in the cost of institutional health care at higher rate than increases in taxable earnings. Yet, as the trustees recognize, even these projections could be optimistic.

Health care inflation also has serious consequences for the Federal budget. Over time, there has been a massive shift of funding to the health sector. During a 5-year period, 1970–75, health-related outlays rose 74.1 percent, from $18.3 to $31.9 billion annually. Because inflation is a large factor in these outlays, we convert the figures to constant 1969 dollars and find that the increase is still 40.5 percent. This increase should convince anyone that something is going seriously wrong. Health care accounts for $37.9 billion of the recently approved fiscal year 1977 budget. This figure is second only to national defense, if we put interest on the national debt and income security disbursements in special categories. Clearly, the trend in Federal spending for health care is crowding out other priorities.

Unfortunately, the reaction of some policymakers to this inflationary trend has been to propose methods to restrain its impact on programs within the Federal budget. Our organizations have consistently opposed such proposals. All they would do is shift an increased financial burden onto individual health care users and medicare beneficiaries. The problem is to deal with the sectorial causes of health care inflation, not just one of its effects.

We think there needs to be greater concern for the consequences to individuals, especially the elderly. Increasing numbers of elderly persons, even with medicare protection, are being priced out of the health care market.

It is a tragic consequence for the elderly that medicare has reinforced health care inflationary trends, whereas the medicare program was planned to extend to the elderly a large measure of relief over their medical bills. The Social Security Administration has computed that in 1967, medicare's first year of full operation, the average bill per aged person was $532, of which 31.8 percent was paid by medicare. By last year, the average bill had doubled to $1,052. About 40.3 percent was paid by medicare. The program picked up 9 percent more of the tab, but, in the meantime, the health bill had doubled. The aged individual is responsible for meeting the difference out of his own pocket or through some type of supplementary insurance.

It has been argued that the indexing of social security cash benefits through the Consumer Price Index is compensating. But medical services are rising in price faster than the general index of consumer prices. What the Government has been giving in larger cash benefits is being dissipated through the inflation of medical care bills.

If the trends in health care inflation continue, medical services will be priced out of reach of the average citizen, and the costs associated with national health insurance will put that goal totally out of reach. As a nation, we cannot continue to allocate an ever-increasing percentage of our resources to the health sector.

CAUSES OF HEALTH CARE INFLATION

The causes for the elevated health care inflation rate are numerous. While a full discussion of them is outside the scope of our testimony, prime factors are: (1) the third-party payment system (both Government and private) and (2) the circumstances under which the consumer has little choice in his selection of services and exercises little scrutiny over the costs of services.

When the outlays for health in the Nation become so large it is natural to question whether or not we might be better off by spending less on formal health care and more in cleaning up our environment, more on housing, more on better nutrition, more on a host of other priorities. Yields of the present health system with respect to longevity have reached the point of diminishing returns against large increases in expenditures.

SHORT- AND MID-TERM REMEDIES

The health care industry cannot be dealt with in a general way along with the rest of the economy. Health care price increases must be controlled.

We wish to make it clear, however, that we are not simply opting for an immediate return to the economic stabilization program's (ESP) controls over the health sector. While the Council on Wage and Price Stability found that health care prices rose more slowly than other prices under the influence of the program then in effect, other studies have raised much doubt that the program effectively restrained health care costs.

Our organizations are proposing that caps be placed over price increases by institutional providers of health services. We are not recommending a freeze, because we wish no interruption of services; obviously, providers must deal in turn with inflation of factor prices. We are recommending that year-to-year increases in billings of health care providers, irrespective of the source of payment, government or private, be limited to the average increase in consumer prices in all other segments of the economy plus an additional three or four percent to permit the industry to adjust to controls. The incremental amount should be phased down in subsequent years until the average increase is held to the increase in consumer prices in other economic sectors. The base for the ceiling would be determined by the increase in the CPI with the medical items excised from the computations.

The only exception to the ceilings should be for institutions in States or areas where malpractice suits are the cause of large increases in the costs. The controls program should be under a reinforced Council on Wage and Price Stability but should utilize existing State agencies and commissions where feasible.

Simultaneously, a prospective payment system should be developed with respect to institutional providers to get away from cost reimbursement. Our organization views such a system as encompassing prospective budget approval, standard accounting practices, rate setting, and periodic payment on the basis of approved budgets and rates. While regulating the price of hospital services will obviously involve many technical problems and may cause some distortions and inequities, it seems to be the only immediate way to deal with chronic inflation in hospital costs. Rate setting should be reinforced by additional regulatory instruments such as certificates of need, utilization review, minimum standards of quality, and health resource planning.

While we view regulation of the price of hospital care as the only realistic means of dealing with inflation in the health sector at the present time, it should be adopted along with a start on long-term reform of the health care industry structure.

LONG-TERM REMEDIES: CHALLENGING THE PROCEDURES AND GOALS OF CONVENTIONAL HEALTH CARE DELIVERY

The procedures and goals of the conventional health care delivery system are already being challenged on economic grounds and on the grounds that the goals of the system are too narrow.

The economic grounds for these challenges are that the conventional health care system is medically and institutionally oriented and deals mainly with the treatment of illness. The system is centered around the hospitals and an elite manpower corps of physicians who direct and control the system. The evidence is that all the health care that is being funneled through the system by medicare, medicaid and the insurance institutions results in overloading the system. Because there are no competitive alternatives to the elements in the system, the demand for the services of the system has been driving up the cost of services at rates substantially exceeding the general rate of inflation. The simple facts of the system are that the customers who are patients have nowhere else to go. The hospitals and doctors represent a monopoly and the customers are driven through the doors of the monopoly by government regulations, employers, the insurance companies, organized medicine and the distributors of pharmaceuticals.

It sometimes requires a severe shock to the human system before accepted ways of doing things are reviewed and changed. The virtual bankruptcy of New York City dictated a complete review of health expenditures by the city and by the State. This review has brought into question the methods and goals of accepted health care. The economic challenge to the present system arises when expenditures for health care are not equated with health. In submitting major legislative revisions in health care to the State legislature, Governor Carey was quoted as saying: "We never should have, and we certainly can no longer measure the quality of health services by the amount of money we spend."

The themes of Governor Carey's legislative proposals were the deinstitutionalization of the medical care delivery system, better use of existing resources, and a more ethical and equitable system.

These queries into the goals and procedures of the conventional health care system were dictated by unfavorable economics. However, especially for the elderly, the system must be challenged on the grounds that it fails to meet the real needs of the public.

The reasonable goals of the health system should focus around a definition of health which embraces the ability "to function well physically and mentally and to express the full range of one's potentialities." This goal collides with the limited concerns of medicine (and organized medicine) with its emphasis on the management of disease. Even in the field of preventive medicine, organized medicine is directed toward the prevention of specific diseases rather than toward health maintenance and optimum functioning.

If we accept this definition of health as a goal, we must shift from the traditional emphasis on disease, and from the institutions designed for the treatment of disease to emphasis on private, social and institutional arrangements whereby the elderly are maintained so that the largest number are fully functioning.

In changing our emphasis on goals, we must shift from a heavily institutionalized delivery system, to a system with more elements in it, and one which is likely to be less expensive than the medically oriented one. For one thing, the hospital which has been sapping our resources should be deemphasized, and with this deemphasis, we suspect that many of medicare's cost-control problems will diminish.

Of course, the elderly should have access within their means to the best of hospital services. But, as we see it, a perpetuation of medicare as presently designed and a perpetuation of the present delivery system is not in their interests. We are advocating a ceiling on hospital charges not only until the inflation of their billings is brought down to reasonable levels, but until a health care delivery system is reorganized to meet their needs. We do not want the elderly forced into institutions simply because, living in a community, they are unable to obtain the health and social services they require.

The tremendous sums now being spent on the conventional approach, and the out-of-control costs of the present system, can only mean that we cannot afford two approaches. If we simply try to shore up the medicare program indefinitely under the present delivery system, we will find that it will be like trying to clean out the Augean stables.

CONCLUSION

In conclusion, Mr. Chairman, our organizations are proposing that ceilings be placed on the annual rate of increase in the prices of institutional providers, especially hospitals, while a nationwide system of prospective rate setting is developed, tested, and implemented. We urge this subcommittee and the other committees of the Congress with jurisdiction to accept the challenge and call in the experts to work out the mechanics.

In the long term, however, emphasis must be placed on:

(1) The utilization of lower levels of care, in a complete continuum of services.

(2) Resource planning and the promotion of competition within the industry though the encouragement of HMO's, public health clinics and other ambulatory facilities.

My associates and I will try to respond to any questions that you or other members of the subcommittee may have, including any on S. 3205 (H.R. 13080).

[The prepared statement follows:]

STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

I am Ralph Borsodi, a retired economist and consultant to the National Retired Teachers Association and the American Association of Retired Persons. These affiliated organizations have a combined membership of over 9.5 million older persons.

With me today are Mr. Lawrence F. Lane and Mr. James M. Hacking, both members of the Associations' legislative staff.

We are responding to the Subcommittee's request for testimony on given issues under the Medicare program and specifically, on your topic #9.[1] Our Associations endorse annually determined ceilings on hospital cost increases. We propose that Medicare not recognize hospital costs as reasonable, unless the costs are within these ceilings. We propose that these ceilings continue until the prospective reimbursement system is installed and effective or until the inflation rate of hospital costs does not exceed the general inflation rate of the economy. We do not, however, think that Medicare problems can be treated in isolation. To avoid discrimination against Medicare beneficiaries and a lateral shift of a higher financal burden to non-Medicare hospital inpatients, the ceilings must be applied to all hospitals and all third-party payors must observe them.

I. THE PROBLEM: CHRONIC INFLATION

Over the period 1965 to 1975, health expenditures increased from 5.9 percent to 8.3 percent of our gross national product—an increase of 41 percent in one decade.[2] Health care expenditures tripled from $39 billion to $119 billion; the 1974–75 increase of $14.5 billion was the largest ever.[3]

---

[1] Considerations for and against imposing, prior to the full implementation of a prospective reimbursement system, a ceiling on total hospital cost increases recognized as reasonable by medicare; methods for establishing such a ceiling and for recognizing and allowing exceptions to the ceiling.

[2] Council on Wage and Price Stability, "The Problem of Rising Health Care Costs," 1 (April 1976) (hereinafter referred to as Council's Rept.).

[3] Id. at 2.

Price increases for medical services over the last decade have significantly outpaced increases in other consumer service prices, with the disparity accelerating more rapidly during 1975.[4] The cost of an average hospital stay is up from $311 in 1965 to $1,017 in 1975. The medical care services component of the Consumer Price Index rose 10.3 percent in 1975, with hospital service charges rising by 13 percent and physician fees rising by 11.8 percent.[5] By way of contrast, the CPI's overall service component (less medical services) rose only 7.7 percent.

During the first quarter of 1976, medical prices rose at an annual rate of 14 percent, whereas the GNP deflator index rose at a moderate rate of 3.7 percent and the CPI at an even more moderate rate of 2.9 percent. It is clear to us that forces within the health sector are driving medical service prices widely out of line.

II. THE FORECASTS: MORE OF THE SAME

We are deeply disturbed that the forecasts for health service prices call for more of the same elevated price trends. The consensus of the forecasts of inflation rates for the current year is that the annual rate of price inflation as measured by the CPI will fall between 5 and 6 percent. This index includes items for medical care and would be less if the items were removed from the index.

Our Associations are anything but pleased with this so-called hard-core level of inflation. Annual rates of 5 to 6 percent are economically destructive in the sense that only special sectors of the economy can live with them year after year. But contrast these general rates for goods and services with the inflation expected in hospital costs for this year. While the Trustees of the Hospital Insurance Trust Fund expect hospital admissions to rise 1.5 percent during 1976, they expect inpatient costs in the aggregate to rise by 15.9 percent.[6] They foresee no appreciable moderation in these rates of increase for years to come.

III. THE CONSEQUENCES OF THIS INFLATIONARY TREND

For the Hospital Insurance program, the consequences of this trend are serious. The ratio of expenditures to taxable payroll has increased from 0.95 percent in 1967 to an estimated 1.73 percent in 1975.[7] This reflects both the higher rate of increase in hospital costs than in earning subject to HI taxes and the extension of HI benefits to disabled beneficiaries and persons suffering from chronic renal disease. Further, increases in this ratio to 2.26 percent in 1980 and to 4.93 percent in the year 2000 result from the assumed continuation of increases in the cost of institutional health care at a higher rate than increases in taxable earnings.[8] The Trust Fund as a percent of a year's disbursements is projected to remain relatively stable in the range of 55–60 percent through 1980, to increase somewhat during the early 80's to a level of approximately 75 percent at the beginning of 1985, and to decline thereafter until the Trust Fund is completely exhausted in the early 1990's.[9]

But even these projections could prove to be optimistic. Under the third set of alternative assumptions used by the HI Trustees, the Trust Fund as a percent of a year's disbursements is projected to decrease steadily over the next 10 years with complete exhaustion of the Trust Fund in the mid-1980's.

The health care inflationary trend also has serious consequences for the federal budget. Disbursements from the Hospital Insurance Trust Fund in fiscal year 1975 totalled $10.6 billion—a 32-percent increase over fiscal year 1974.[10]

Since the increase in disbursements under the HI program is typical of most of the federal health programs, it is not surprising that the budget for the federal government reflects a massive shift of funding to the health sector. During a five-year period, 1970–75, health-related outlays of the Federal Government rose 74.1 percent, from $18.3 to $31.9 billion annually. Because inflation is a large factor in these outlays, we convert the figures to constant 1969 dollars and find that the increase in constant dollars is 40.5 percent. This increase should concern anyone that something is seriously wrong. The position that health care has assumed in the nation's budget is shown by the figure of $37.9 billion in the recently approved fiscal year 1977 budget. This figure is second only to national defense, if we exclude interest on the national debt and income security disbursements, both of which figures have special characteristics. Clearly, the trend in federal spending for health care is crowding out other budgetary priorities.

---

[4] See Table I in Appendix, p. 23. Reproduced from Council's Rept. 7 (Table IV). For a comparison of rates of price increases for different items in 1975, see Table II in Appendix, p. 24. Table reproduced from Council's Rept. 6 (Table III).

[5] See Table III in Appendix, p. 25. Reproduced from Council's Rept. 7 (Table II).

[6] See Table IV in Appendix, p. 26. Reproduced from Board of Trustees of the Federal Hospital Insurance Trust Fund, 1976 Annual Report 44 (May 1976(Table A–1) (hereinafter referred to as 1976 HI Trustees' Rept.).

[7] 1976 HI Trustees' Rept. at 27.

[8] See Table V in Appendix, p. 27, Table reproduced from 1976 HI Trustees Report at 60 (table A–3).

[9] See Table VI in Appendix, p. 28, for actuarial balance of the HI program under alternative sets of assumptions. Table reproduced from 1976 HI Trustees Report at 37 (table 11).

[10] 1976 HI Trustees Report at 2.

Unfortunately, the reaction on the part of policymakers to the inflationary trend in health care has been to propose methods to restrain the impact of that trend on the Federal budget. Our organizations have consistently opposed such proposals. All they would do is shift an increased financial burden onto the individual health care users and medicare beneficiaries. The problem is to deal with the sectorial causes of health care inflation, not just one of its effects.

While we can appreciate concern for the federal budgetary consequences, we think there needs to be greater concern for the consequences to individuals, especially the elderly. Increasing numbers of elderly persons, even with Medicare protection, are being priced out of the health care market.

On a per capita basis, personal health care expenditures for the population as a whole climbed to $476 in fiscal year 1975.[11] But for persons aged 65 and older, the $1,360 per capita expenditure was more than 6 times the average expenditure for those under age 19 ($212) and almost 3 times the average expense for those aged 19–64 ($472).

It is a tragic consequence for the elderly that medicare has reinforced health care inflationary trends, whereas the medicare program was planned to extend to the elderly a large measure of relief over their medical bills. On medical billings, the Social Security Administration has computed that in 1967, its first year of full operation, the average bill per aged person was $532, of which 31.8 percent was paid by medicare. By last year, the average medicare bill had doubled to $1,052, of which 40.3 percent was paid by medicare. Medicare picked up 9 percent more of the tab, but in the meantime, the health bill had doubled. The aged individual becomes responsible for meeting the difference out of his own pocket or through some type of supplementary insurance.

While it is true that direct payments by consumers represent less than a third of their total health expenditures in 1975, compared with a little more than half 10 years earlier, the dollar amounts per capita rose 65 percent from 1966 to 1975—from an average of $94 to $155. But, for the elderly, this direct payment trend has been more serious. On a per capita basis, persons under age 65 in 1975 spent $128.11 directly for personal health care; the elderly, however, paid out $389.88.[12] Despite their third party payments (which covered 71.3 percent of the elderly's per capita health care bill in 1975), 29 percent came from their own limited resources.

It has been argued that the indexing of social security cash benefits through the Consumer Price Index is compensating. This new procedure is certainly helpful, but social security income is only a portion of the income of the elderly and this other income tends to be fixed. Medical services are rising in price faster than the general index of consumer prices and the index is used to raise social security retirement checks after inflation has taken place. What the government has been giving in larger cash benefits is being dissipated through the higher inflation of medical care bills.

Although we have been pressing the point of view of our elderly membership, the young, the middle aged, businessmen and insurers, all suffer in varying degrees from the rocketing growth of medical costs.

If the trends in health care inflation continue, health care services will be priced out of reach of the average citizen and the costs associated with national health insurance will put that goal totally out of reach. As a nation, we cannot continue to allocate an infinitely increasing percentage of our resources to health care.

IV. CAUSES OF HEALTH CARE INFLATION

The causes for the elevated rate of inflation for health services are many. While a full discussion of them is outside the scope of our testimony, we do believe that prime factors are: (1) the third-party payment system (both government and private) and (2) the circumstances under which the consumer has little choice in his selection of services and exercises little scrutiny over the costs of services. We expect the debate over the causes, their relative importance, and the specific corrections needed will continue for years. In the meantime, the nation's health bill continues to inflate at a rate higher than before with consequences that are grave for everyone, especially the elderly and the poor.

---

[11] See Table VII in Appendix, p. 29. Reproduced from 6 Social Security Bulletin 29 (1976) (Table 7).

[12] Again, see Table VII in Appendix, p. 29.

When the outlays for health in the nation become so large it is natural to question whether or not we might be better off by spending less on formal health care and more in cleaning up our environment, more on housing, more on better nutrition, more on mass transit, more on meeting unemployment, and more on a host of other social problems. Large increments to health expenditures are not yielding anything but marginal returns in the way of adding time to our life expectancy. Yields of the present health care system with respect to longevity have reached the point of diminishing returns against large increases in expenditures.

V. SHORT AND MIDTERM REMEDIES

As a first priority, we must address ourselves to the circumstance that the health care industry cannot be dealt with in a general way with the rest of the economy; health care price increases must be controlled.

We wish to make it clear, however, that we are not simply opting for an immediate return to the economic stabilization program's controls over the health sector. While the Council on Wage and Price Stability found that, during the period from August 1971 through April 1974, health care prices rose more slowly than other prices under the influence of the program then in effect, other economists have disputed the efficacy of the program in its application to the health sector. For example, Prof. Paul Ginsberg of Duke University, in an analysis of the impact of the economic stabilization program on hospitals, found that, while the program did restrain hospital employee wage levels somewhat, the structure of a program was such that it did nothing to change the trend toward substantial increases in factor inputs per admission of per patient day.[13]

In addition, he asserts that the use of the CPI gives a misleading impression of what really happened to hospital costs during the control period.[14]

Our organizations are proposing that caps be placed over price increases by institutional providers of health services. We are not recommending a freeze in prices, because we wish no interruption of services; obviously, providers must deal in turn with inflation of their own costs. We are recommending that year-to-year increases in billings of health care providers, irrespective of the source of payment, government or private, be limited to the average increases in consumer prices in all other segments of the economy plus an additional 3 or 4 percent which incremental amount should be phased down in subsequent years until the average increase is held to the increase in consumer prices in other economic sectors. The base for the ceiling would be simply determined by the increase in the CPI with the medical items excised from the computations. The latest published monthly figure of this special index would serve to guide health providers in their billings.

---

[13] See Tables VIII and IX in Appendix, pp. 30, 31. In describing the Economic Stabilization Program with respect to health care institutions, Professor Ginsberg states:

"Initially, a 6-percent limit was placed on service charge increases for institutional providers. Consistent with the rest of the controls program, all price increases had to be cost-justified and an institution's profit margins could not exceed that from a base period. In addition, there were limitations on cost increases that could be used for justification of price increases. Limitations were 5.5 percent for wages, 2.5 percent for non-labor costs, and an additional factor of 1.7 percent for new technology.

"Noting that hospital revenue could not be controlled under these mechanisms because most patients were financed by third-party payors which reimbursed the hospital for its costs, the Price Commission, in a preamble to its regulations, defined payments from reimbursers to be priced. Limitations were applied to revenue increases due to price instead of to increases in charges. As a result, a method to separate revenue changes corresponding with changes in volume from those due to price increases was needed. Months passed, however, before the extent of ambiguity was perceived. Finally, hospitals were given a choice of adjusting for volume through detailed service data or through use of a formula. The formula was initially a weighted average of admissions and outpatient visits with adjustment for intensity increases (per admission) based on recent national trends in input intensity. Thus, one of the alternative volume adjustments did not control intensity in any way while the other limited each hospital's intensity to a continuation of past industry-wide trends."

[14] The most serious problem, however, is the use of charge data from the Consumer Price Index instead of data on revenue per unit of output. With the extensive use of third-party cost reimbursement, charges are paid only by a minority of patients. Thus, a series of charges is an imperfect indicator of revenues. This was the case for the ESP. From 1971 (2nd quarter) to 1973 (2nd quarter), semi-private room charges increased at an annual rate of 5.8 percent, while inpatient revenues per inpatient day increased at a 9.3 percent annual rate. Hospital charges were much easier to monitor than revenues from reimbursement of costs and this is the proper cause of this large discrepancy.

The only exception to the ceilings on price increases should be for institutions in state or areas where malpractice suits are the cause of large increases in the costs of health providers. Perhaps this is not as pervasive a problem as the press would have us believe. However, until the excesses of malpractice suits are dealt with legislatively, we must recognize that this is an extraordinary item of cost. The controls program should be under the Council on Wage and Price Stability but should utilize existing state agencies and commissions where feasible.

Simultaneously, every effect should be made to foster the development of prospective payment systems with respect to institutional providers to get away from cost reimbursement. Our organizations view such a system as encompassing prospective budget approval, standard accounting practices, rate setting, and periodic payment on the basis of the approved budget and rates.[15]

While regulating the price of hospital services will obviously involve many technical problems and may cause distortions in the production of hospital services, it seems to be the most reasonable instrument to deal with chronic inflation in hospital costs caused by third-party financing of hospital care with service benefit policies. Obviously, rate setting will have to be reinforced by additional regulatory instruments such as certificate of need, utilization review, minimum standards of "quality" and health resource planning.

While we view regulation of the price of hospital care as the only realistic means of dealing with inflation in the health sector at the present time, thought must also be given now to long-term reform.

VI. LONG-TERM REMEDIES: CHALLENGING THE PROCEDURES AND GOALS OF CONVENTIONAL HEALTH CARE DELIVERY

Some have challenged the procedures and goals of the conventional health care delivery system on economic grounds and on the grounds that the goals of the system are too narrow. We too are challenging the procedures and goals of the accepted health care delivery system which is hospital-centered.

Let us first review the economic grounds for these challenges. The conventional health care system is medically and institutionally oriented and deals with the treatment of illness, centered around hospital care. The hospital is an institution for the treatment of acute, episodic illness. An elite manpower corps of physicians direct and control the system. The evidence is that all the health care that is being funneled through the system by Medicare, Medicaid, and the insurance institutions results in overloading the system. Because there are no competitive alternatives to the elements in the system, the demand for the services of the system has been driving up the cost of services at rates substantially exceeding the general rate of inflation. These economics have been obscured by the great expansion of the health care industry and endless studies of changing scenes (as to whether increases in costs are demand/pull or cost/push). The simple facts of the system are that the customers (patients) have no where else to go. The hospitals and doctors represent a monopoly and the customers are driven through the doors of the monopoly by government regulations, employers, the insurance companies, organized medicine and the distributors of pharmaceuticals.

It sometimes requires a severe shock to the human system before accepted ways of doing things are reviewed and changed. The virtual bankruptcy of New York City, which threatened New York State, dictated a complete review of the expenditures by the City and by the State for health. This review has brought into question the methods and goals of accepted health care. The economic challenge to the present system begins when expenditures for health care are not equated with health care. Although we have long suspected that state expenditures on roads not always wound up in pavements, it has been assumed that health care expenditures are good because they are protected by the standards of the medical profession and directed by the latest in scientific research. In submitting major legislative revisions in health care in the New York State legislature, Governor Carey was quoted as saying: "We never should have, and we certainly can no longer measure the quality of health services by the amount of money we spend." (New York Times, Feb. 5, 1976.)

---

[15] Under the Comprehensive Medicare Reform Act of 1975 (S. 1456), the amount of payment to a participating institutional provider for institutional services is to be made on the basis of a pre-determined schedule of patient care charges approved (for an accounting year in the institution) by the Secretary of HEW (through a review mechanism under which the fiscal intermediary for the institution generally makes the initial determination) or, in a state that has a state rate and review agency operating under equivalent standards, approved by that state agency. (Capitation charges, if submitted by a provider and if meeting standard, may also be approved.) This schedule of charges must be based on a system of accounting and cost finding in conformity with standards prescribed or approved by the Secretary, and are the institution's budget for the accounting year involved, which budget must also be approved by the Secretary or the State Rate Review and Approval Agency. as the case may be. A schedule of charges may be approved only if they do not exceed the estimated reasonable cost for the efficient delivery of services, as determined under the definition of "reasonable cost" and implementing regulations.

The themes of Governor Carey's legislative proposals were the deinstitutionalization of the medical care delivery system, better use of existing resources, and a more ethical and equitable health care system. Community health care systems and health maintenance organizations with prepaid group medical practice plans are to be sponsored. The expansion of the role of nurses in health care was proposed, relieving pressure on the medical profession. Insurance plans which foster unnecessary medical services (operations) were questioned. Insurance plans which failed to foster outpatient treatment were also questioned. The training of family care physicians is to be encouraged.

These queries into the goals and procedures of the conventional health care system arose because of unfavorable economics. However, especially for the elderly, the system must be challenged on the grounds that it fails to meet their real needs.

A special symposium of the 24th annual meeting of the American Gerontological Society (October 29, 1971) resulted in some notes entitled, "Comprehensive Health Care for the Elderly: An Analysis (The Continuum of Medical, Health and Social Services for the Aging)". These notes are valuable because they take a fundamental look at the health goals of the elderly, the goals of the conventional health delivery system and why these goals fail to meet the needs of the elderly, and the character of a system which would better fit their needs. The point was made that there were no less than 16 different programs labelled comprehensive health plans before the Congress in 1971 which could not be evaluated in the absence of benefit criteria. Criteria were held to be meaningless when not related to specific goals to acceptable standards of performance.

The goals of health, and they particularly concern the elderly, focus around a definition of health which described the ability "to function well physically and mentally and to express the full range of one's potentialities." This goal collides with the concerns of medicine (and organized medicine) with its emphasis on the management of disease. Even in the field of preventive medicine, organized medicine is directed toward the prevention of disease rather than toward health maintenance and optimum functioning. The concern of the conventional health system is more with the quantity of life and less with the quality of life.

If we accept this new definition of health as a goal, we must shift from the traditional emphasis of medicine on disease and from the institutions designed for the treatment of disease to emphasis on private, social and institutional arrangements whereby the elderly are maintained so that the largest number are fully functioning.

In changing our emphasis on goals, we must shift from a heavily institutionalized health care delivery system, to a system with more elements in it, and one which at least New York State has concluded is likely to be less expensive than the medically-oriented one. For one thing, the hospital which has been sapping our resources for capital, physicians and other trained personnel, will be deemphasized, and with this deemphasis, we suspect that many of Medicare's cost-control problems will be deemphasized.

Of course, the elderly should have access within their means to the best of hospital services. But as we see it, a perpetuation of Medicare as presently designed and a perpetuation of the present health care delivery system is contrary to their interests. We are advocating a ceiling on hospital charges not only until the inflation of their billings is brought down to reasonable levels, but until a health care delivery system is reorganized to meet their needs. We do not want the elderly forced into institutions simply because living in a community they are unable to obtain the health and social services they require.

The 1976 NRTA-AARP Legislative Program contains 26 points of legislation reform under the headings of long-term care, mental health, medical resources and facilities, and pharmaceuticals. These points cover a continuum of services which will go a long way toward enabling the elderly to function optimally. What fails to emerge from a setting down of these points is that there is a fundamental conflict between the heavily medical and institutionalized approach to health care with an approach to health care with broader goals and using a wider range of services to support these goals. The tremendous sums now being spent on the conventional approach, and the out-of-control costs of the present system, can only mean that we cannot afford the two approaches. If we simply try to shore up the Medicare program indefinitely under the present health care delivery system, we will find that it will be like trying to clean out the Augean stables.

VII. CONCLUSION

In conclusion, Mr. Chairman, our organizations are proposing that ceilings be placed on the annual rate of increase in the prices of institutional providers, especially hospitals, while a nationwide system of prospective rate setting is developed, tested and implemented. We urge this Subcommittee and the other Committees of the Congress with jurisdiction to accept the challenge and call in the experts to work out the details.

In the long term, however, emphasis must be placed on: (1) the utilization of lower levels of care (in a complete continuum of services); (2) resources planning and the promotion of competition within the industry through the encouragement of HMO's, public health clinics and other ambulatory facilities.

My associates and I will try to respond to any questions that you or other members of the Subcommittee may have, including any on S. 3205 (H.R. 13080).

Appendix

TABLE I.—ANNUAL RATES OF PRICE INCREASES

[In percent]

	Premedicare July 1959–June 1966	Postmedicare June 1966–June 1971	Controls August 1971–April 1974	1974 Postcontrols April 1974–December 1974	1975 December 1974–December 1975
CPI, all services less medical care	2.0	5.8	5.2	9.5	7.7
CPI, medical care services	3.2	7.9	4.9	12.1	10.3
Hospital service charges	NA	NA	4.6	14.6	13.0
Semiprivate room charge	6.0	14.8	5.7	16.9	14.7
Physicians' fees	2.9	6.9	4.0	12.8	11.8
Dentists' fees	2.3	5.9	4.2	9.6	7.8
Drug and prescriptions	—.7	1.0	.7	7.8	7.4

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Table II—Comparative Rates of Price Increase: 1975

[Percentage change, December 1974–December 1975]

Hospital service charges	13.0
Physician fees	11.8
Food	6.5
Homeownership	7.9
Rent	5.2
Fuel and utilities	11.2
New cars	7.3
Used cars	8.1
Gasoline and motor oil	10.5
All services (other than medical)	7.7
Dry cleaning	7.6
Domestic services	5.4
Auto repairs	9.3
Recreational services	3.5
Personal care services	6.4

Source: U.S. Department of Labor, Bureau of Labor Statistics.

TABLE III.—HEALTH CARE PRICE INCREASES: 1975[1]

[In percent]

	Percentage change December 1974–December 1975	Percentage of total health care spending
CPI, all items	7.0	
Less medical care	6.8	
CPI, all services	8.1	
Less medical care	7.7	
CPI, medical care, services	10.3	
Hospital service charges	13.0	39.3
Physician fees	11.8	18.6
Dental fees	7.8	6.3
Drugs and prescriptions	7.4	8.9
CPI, medicare care, total	9.9	

[1] The Consumer Price Index for medical care and its various components have frequently been criticized as not adequately accounting for changes in quality and product mix; to the extent they understate these changes, they mey overstate true price increases. Similar problems are encountered in measuring price changes for other services. The Council staff recognizes these shortcomings, and plans to work in the future with appropriate Government agencies and the medical care sector to improve the measures of medical care prices.

Source: U.S. Department of Labor, Bureau of Labor Statistics; U.S. Department of Health, Education, and Welfare, Social Security Administration.

TABLE IV.—COMPONENTS OF HISTORICAL AND PROJECTED INCREASES IN HOSPITAL COSTS

[Percent]

Calendar year	Economic factors			Volume of services [2]		Unit input intensity [2]				Aggregate inpatient hospital costs [4]	HI share		HI inpatient hospital costs
	Average wages	CPI	Weighted average [3]	Total population	Admission incidence	Wage level	Employee intensity	Nonlabor intensity	Weighted average [3]		Proportion of population	Other sources	
1958–65	3.7	1.6	3.0	1.6	1.7	1.0	2.0	5.3	4.1	10.4			
1966	5.5	3.0	4.6	1.1	.5	−4.7	8.2	8.4	5.5	11.7			
1967	5.7	2.8	4.7	1.1	−.7	3.4	6.2	18.4	13.5	18.6			
1968	6.4	4.2	5.7	1.0	.1	3.3	4.4	11.6	9.7	16.5	0.6	7.5	24.6
1969	6.6	5.4	6.5	1.0	2.6	2.7	3.5	9.9	8.3	18.4	.5	−3.7	15.2
1970	5.3	5.9	6.0	1.1	2.4	4.5	1.3	8.3	7.3	16.8	.5	−5.3	12.0
1971	5.4	4.3	5.2	1.0	2.0	4.6	−.1	6.1	5.5	13.7	.6	−.3	14.0
1972	6.9	3.3	5.5	.9	1.2	1.2	.2	11.3	5.9	13.5	.7	−4.5	9.7
1973	6.3	6.2	6.5	.7	2.4	−1.6	0	3.1	.5	10.1	5.3	−.9	14.5
1974	7.0	11.0	9.2	.7	3.0	−1.2	2.3	2.0	1.6	14.5	6.0	3.4	23.9
1975	6.8	9.1	8.3	.7	1.0	2.5	2.8	8.0	6.9	16.9	2.2	6.4	25.5
1976	7.7	6.3	7.4	.7	1.5	3.1	1.5	7.5	6.3	15.9	1.5	1.6	19.0
1977	8.5	6.0	7.7	.7	1.5	2.3	1.5	7.5	5.9	15.8	1.4	.2	17.4
1978	9.4	6.0	8.1	.7	1.5	1.0	1.5	7.0	4.9	15.2	1.3	.1	16.6
1979	8.5	5.5	7.4	.7	1.5	1.4	1.5	7.0	5.1	14.7	1.2	−.2	15.7
1980	7.7	5.0	6.7	.7	1.5	1.7	1.5	7.0	5.2	14.1	1.2	−.3	15.0
1985	5.8	4.0	5.0	.7	.9	.7	1.5	5.5	4.0	10.6	1.3	−.3	11.6
1990	5.8	4.0	5.0	.6	.3	.7	1.5	5.5	4.0	9.9	.9	−.2	10.6
1995	5.8	4.0	5.0	.5	.3	.2	1.0	5.5	3.6	9.4	.5	−.2	9.7
2000	5.8	4.0	5.0	.4	.4	.2	1.0	5.5	3.6	9.4	.3	−.1	9.6

[1] Percent increase in year indicated over previous year.

[2] Based on data from the American Hospital Association through 1974.

[3] Weighted average of the individual components, with adjustments for the effects of compounding. The weightings are based on the proportions of aggregate inpatient hospital costs which are for payroll and for nonpayroll expenses. The adjustments for the effects of compounding are necessary to compensate for the fact that the various components actually are multiplicative, rather than additive as illustrated in this table.

[4] Includes hospital costs for all patients.

TABLE V. SUMMARY OF ALTERNATIVE COST PROJECTIONS FOR THE HI PROGRAM[1]

[In percent]

	Increases in aggregate inpatient hospital costs[2]				Relationship between costs and payroll			
Calendar year	Average wages	CPI	Volume and intensity	Total	Program costs[3]	Taxable payroll	Ratio of costs to payroll	Expenditures as a percent of taxable payroll
Alternative I:								
1976	7.7	6.3	8.5	15.9	20.3	11.7	7.7	1.87
1977	8.5	6.0	7.5	15.3	17.5	12.0	4.9	1.96
1978	9.6	5.5	6.1	14.0	15.8	12.0	3.4	2.02
1979	9.1	5.0	6.1	13.5	14.9	11.9	2.7	2.08
1980	8.1	4.0	6.1	12.6	13.9	11.2	2.4	2.12
1985	5.3	3.0	3.7	7.9	8.9	6.3	2.4	2.40
1990	5.3	3.0	3.0	7.2	7.9	5.9	1.9	2.71
1995	5.3	3.0	2.5	6.7	7.0	5.9	1.0	2.95
2000	5.3	3.0	2.5	6.7	6.9	5.9	0.9	3.08
Alternative II:								
1976	7.7	6.3	8.5	15.9	20.3	11.7	7.7	1.87
1977	8.5	6.0	8.1	15.8	18.0	12.0	5.4	1.97
1978	9.4	6.0	7.1	15.2	17.0	11.1	5.3	2.07
1979	8.5	5.5	7.3	14.7	16.1	10.9	4.7	2.17
1980	7.7	5.0	7.4	14.1	15.4	10.5	4.4	2.26
1985	5.8	4.0	5.6	10.6	11.6	6.9	4.4	2.82
1990	5.8	4.0	4.9	9.9	10.6	6.4	3.9	3.54
1995	5.8	4.0	4.4	9.4	9.6	6.4	3.0	4.27
2000	5.8	4.0	4.4	9.4	9.5	6.4	2.9	4.93
Alternative III:								
1976	7.7	6.3	8.5	15.9	20.3	11.7	7.7	1.87
1977	8.0	6.0	8.9	16.4	18.5	10.7	7.0	2.00
1978	8.9	6.5	8.1	16.2	18.0	10.3	7.0	2.14
1979	7.9	6.0	8.4	15.7	17.0	9.7	6.7	2.28
1980	7.4	5.5	8.3	15.1	16.6	9.6	6.4	2.42
1985	6.3	5.0	7.4	13.3	14.3	7.4	6.4	3.26
1990	6.3	5.0	6.7	12.5	13.2	6.9	5.9	4.47
1995	6.3	5.0	6.2	12.0	12.1	6.9	5.0	5.91
2000	6.3	5.0	6.2	12.0	12.1	6.9	4.9	7.52

[1] Percent increase in year indicated over previous year.
[2] Includes hospital costs for all patients.
[3] Includes costs attributable to insured beneficiaries only.

TABLE VI.—ACTUARIAL BALANCE OF THE HOSPITAL INSURANCE PROGRAM UNDER ALTERNATIVE SETS OF ASSUMPTIONS

[In percent]

	Alternative I	Alternative II	Alternative III
Average contribution rate, scheduled under present law[1]	2.75	2.75	2.75
Average cost of the program, for expenditures and for trust fund building and maintenance[2]	2.59	3.39	4.39
Actuarial balance	+.16	−.64	−1.64

[1] Average for the 25-yr period 1976–2000.
[2] Average for the 25-yr period 1976–2000, expressed as a percent of taxable payroll.

Source: Social Security Administration.

TABLE VII.—AMOUNT AND PERCENT OF EXPENDITURES FOR PERSONAL HEALTH CARE MET BY 3D PARTIES FOR 2 AGE GROUPS, FISCAL YEARS 1973–75

Fiscal year	Total	Direct payments	3d-party payments			
			Total	Private health insurance	Government	Philanthropy and industry
All ages:						
Total amount (in millions):						
1973	$82,490	$30,348	$52,142	$20,955	$20,062	$1,125
1974	90,088	31,310	58,778	24,100	33,458	1,220
1975	103,200	33,600	69,600	27,340	40,024	1,337
Per capita amount:						
1973	386.84	142.32	244.53	98.27	140.98	5.28
1974	419.44	145.77	273.66	112.21	155.78	5.68
1975	476.40	155.11	321.30	126.21	188.92	6.17
Percent distribution:						
1973	100	36.8	63.2	25.4	36.4	1.4
1974	100	34.8	65.2	26.8	37.1	1.4
1975	100	32.6	67.4	26.5	39.7	1.3
Under age 65:						
Total amount (in millions):						
1973	$59,371	$22,712	$36,659	$19,697	$15,937	$1,025
1974	64,342	22,769	41,572	22,654	17,807	1,111
1975	72,817	24,890	47,926	25,699	21,007	1,220
Per capita amount:						
1973	309.45	118.38	191.07	102.67	83.07	5.34
1974	333.39	117.98	215.41	117.38	92.27	5.76
1975	374.79	128.11	246.68	132.28	108.12	6.28
Percent distribution:						
1973	100	38.3	61.7	27.3	26.8	1.7
1974	100	35.4	64.6	28.0	27.7	1.7
1975	100	34.2	65.8	28.7	28.8	1.7
Aged 65 and over:						
Total amount (in millions):						
1973	$23,119	$7,636	$15,483	$1,257	$14,126	$100
1974	25,746	8,540	17,206	1,446	15,651	109
1975	30,383	8,709	21,674	1,640	19,917	116
Per capita amount:						
1973	1,081	357.16	724.19	58.81	660.69	4.70
1974	1,181	391.90	789.56	66.35	718.20	5.01
1975	1,360	380.88	970.28	73.44	891.63	5.22
Percent distribution:						
1973	100	33.0	67.0	5.4	61.1	4
1974	100	33.2	66.8	5.6	60.8	4
1975	100	28.7	71.3	5.4	65.6	4

TABLE VIII.—RELATIVE CONTRIBUTION OF WAGE AND PRICE INCREASES AND INCREASED FACTOR USE TO RISING HOSPITAL COSTS

[In percent]

	1951–60	1960–65	1965–67	1967–69	1969–71	1971–73
Average annual increase in average expense per patient-day	7.5	6.7	10.3	13.8	14.8	11.5
Portion of increase due to:						
Increases in wages and prices of nonlabor inputs	50.0	51.5	39.7	58.2	55.3	51.3
Increased use of labor and nonlabor inputs	50.0	48.5	60.3	41.8	44.7	48.7

Source: U.S. Department of Health, Education, and Welfare, Social Security Administretion, Medical Care Expenditures, Prices and Costs: Background Book, (September 1975) p. 39.

TABLE IX.—ANNUAL RATES OF INCREASE SELECTED HOSPITAL TIME SERIES

[In percent]

Series	Period 1963 II–1966 II	 1966 II–1969 II	 1969 II–1971 II	 1971 II–1973 II
Nominal terms:				
Expenditures per adjusted admission	8.4	16.7	10.0	8.2
Expenditures per adjusted patient-day	8.6	14.0	12.2	10.2
Inpatient revenue per admission	8.7	16.7	10.2	7.3
Inpatient revenue per patient-day	8.9	14.1	12.6	9.3
Inputs per adjusted admission	3.4	6.8	2.7	9.9
Inputs per adjusted patient-day	3.6	4.3	4.9	12.0
Wages	4.9	9.5	7.2	6.6
Nonlabor input prices	1.8	3.7	3.1	5.1
Real terms:				
Expenditures per adjusted admission	6.3	12.2	4.6	3.7
Expenditures per adjusted patient-day	6.5	9.6	6.6	5.6
Inpatient revenue per admission	6.6	12.2	4.8	2.9
Inpatient revenue per patient-day	6.8	9.7	7.0	4.8
Inputs per adjusted admission	3.4	6.8	2.7	9.9
Inputs per adjusted patient-day	3.6	4.3	4.9	12.0
Wages	2.9	5.2	1.9	2.2
Nonlabor input prices	–.1	–.3	–2.0	.7

Source: National Hospital Panel Survey, Altman and Eichenholz (1974) (nonlabor input prices)

Mr. Rostenkowski. Thank you very much. Are there any questions of the witnesses?

Thank you, Mr. Hawkins and Mr. Rottman. Mr. Rottman, Mr. Pickle was here. Evidently he had another committee meeting to attend. He extends his warm wishes. He has said many nice things about you to members of the subcommittee.

STATEMENTS OF JOE D. HAWKINS, CHAIRMAN, ACCIDENT AND HEALTH INSURANCE SUBCOMMITTEE, TEXAS; AND DICK L. ROTTMAN, PRESIDENT, NEVADA, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. Hawkins. I am Joe Hawkins, and with me is Dick Rottman from the State of Nevada, president of the NAIC, and I will ask Mr. Rottman to make our introductory remarks.

STATEMENT OF DICK L. ROTTMAN

Mr. Rottman. Thank you, Mr. Chairman, and members of the committee. I think before we proceed, it would be important to indicate to you a little about our organizations and National Association of Insurance Commissioners. We have been rather intimately involved in attempting to deal with this problem of rising health care costs and the controls.

Basically, our organization is the oldest association of State officials, and perhaps one of the most effective.

Our main objectives of the organization are to promote uniformity in legislation among the various States, and to assist the chief regulatory officials in the area of insurance.

In recent years, we have been quite active in developing some model laws and legislation designed to improve the health insurance market on a step-by-step program. We recognize that the increasingly high cost of medical care is a serious obstacle to the availability of the necessary care.

This and other problems have been addressed in a series of model bills and regulations adopted by the NAIC, including proposed new laws that remove barriers to the creation of HMO's, apply minimum standards for benefits in individual health insurance, make available catastrophic health insurance, mandate conversion requirements for group insurance coverages, and outline model regulations for health insurance advertising.

Most recently, the NAIC has adopted a model comprehensive health insurance and health care cost containment bill which we would like to discuss with you today, which would be susceptible to passage by the several States. Since Commissioner Hawkins chaired that subcommittee of the NAIC, I think it would be appropriate for him to explain to you some of the features of that particular bill.

Mr. Hawkins. Thank you, Dick.

Mr. Chairman, during the past 14 years as a consulting actuary representing consumers and purchasers of health services and officer of Blue Cross, and later as consultant to providers of health care and State government, I have had occasion to address the issues before your committee from widely different perspectives. As chairman of the NAIC Health Subcommittee, I am responsible to our association for development of appropriate model legislation affecting the health field. I am grateful for this opportunity to appear before your subcommittee to discuss inflationary factors in hospital costs and to offer for your review the NAIC Model Comprehensive Health Insurance and Health Care Cost Containment Act. We have attached a copy of this model to our testimony and I will confine my remarks to the cost containment provisions.

May I stress for the record, however, that my subcommittee concluded early in its study that mandating availability of comprehensive insurance coverage without implementing an effective cost control mechanism would add to the pressure for increased cost. Thus our foremost objective of available and affordable coverage would be defeated. I believe this problem is basic to your search for ways to better control Federal Government expenditures for health care.

When Secretary Weinberger indicated in his testimony in 1975 before your committee "* * * that the faulty design of medicare and medicaid is the principal culprit responsible for * * * inflation in health care costs," his analysis was correct, but incomplete. Although medicare and medicaid have substantially contributed to the skyrocketing costs of medical care, they have contributed no more than the third-party reimbursement system for insurance.

Expenditures for hospital care exceed an annual rate of $50 billion and are escalating at the rate of almost $8 billion per year. Government, both Federal and State, has reacted to this alarming drain on tax revenues by restricting its payments to institutional providers. Hospitals have, in turn, increased charges to the uncontrolled private sector patient. Thus no net reduction in the cost spiral has been achieved by any of the unilateral cutbacks in either Federal or State health programs.

The NAIC is therefore opposed to further reduction in hospital payments under medicare. We believe that reforms in medicare, medicaid and personal health insurance must go hand-in-hand with a commitment to health care cost and quality controls.

At this point let me briefly outline the cost escalation factors we and others have documented. Then I will lay out the provisions of our model act regarding cost and quality controls. And finally I will summarize the NAIC position for State regulation of both rating and cost containment provisions for health care.

FACTORS CONTRIBUTING TO COST ESCALATION FOR HEALTH CARE

In an analysis of the premedicare increases in hospital cost escalation, two researchers, Karen Davis and Richard Foster of the HEW Office of Research and Statistics documented two primary factors in hospital cost escalation: demand and advances in medical technology.

Added to these major factors are contributing inflationary factors which were present in the sixties but increasingly influential in the seventies:

(1) During the past 10 years, hospital wages for nonprofessional staff have risen sharply due to frequent increases in the minimum wage. About 60 percent of a hospital's expenses are directly attributable to wages and fringes. Thus, any pressure on wages leads to immediate increases in charges.

(2) The rapid growth of malpractice suits and large jury awards have greatly intensified the practice of defensive medicine. This may add as much as $5 billion per year in excessive costs to the system.

(3) The patient usually does not pay his bill directly. Since about 90 percent of hospital revenues come from third-party payers, the usual consumer cost-consciousness does not exist.

(4) A large factor is the principle of reimbursing hospitals whatever they spend, a concept embraced by both medicare and medicaid. This reimbursement arrangement has contributed to the unneeded expansion of both equipment and services.

(5) Perhaps the single most important factor is the absence of competition among providers as to both cost and quality.

Providers are therefore free to create the required demand for their services, with little accountability to the public.

I might add at this point that expansion of the third-party reimbursement system has multiplied several of the problems I earlier cited such as consumer cost consciousness and increased utilization of services.

In 1975, total health spending rose to $118 billion which represented 8.3 percent of the GNP versus expenditures of $12 billion or 4.6 percent of the GNP in 1950.

Health expenditures have for many years been rising faster than the national output of goods and services. Per capita health expenditures rose from $257 in 1969 to an estimated $420 in 1974.

Since the termination of the economic stabilization program, medical care prices led by hospital costs have increased at annual rates of 13 to 15 percent.

The health care market provides services to individual patients, but receives two-thirds of its payment from third-party payors.

Prepayment of medical expenses through insurance premiums and taxes unfortunately divorces the purchase of medical care from the individual's restraining influence of household budgets and necessary allocation of household resources.

The consequence is the purchase of increasingly expensive and sophisticated medical care. The loudest consumer cries pointing at the failure of this system come, not unexpectedly, from those not covered by Government programs or group health insurance benefits; namely, individuals that remain as direct purchasers of health care or purchasers of individual health policies.

Dr. Sidney Garfield, the founder of the Kaiser system has succinctly stated our point:

> It should be clear that the cause of today's medical crisis has been the inexorable spread of free care throughout our population.
>
> The effect is an expanded and altered demand that is incompatible with the existing sick-care delivery system, wasting its medical manpower and threatening the quality and economics of the service it renders.

In other words, the problem we see is exacerbated by the expansion of the third-party payment system including private health insurance, both group and individual, medicare, medicaid, and other Government health benefit programs.

Insurance, by prepaying medical services, results in little or no cost to patients at the point of service. The cost problem perpetuated by insurance operates in a circular pattern with insurance at one time purchased to cover the cost of unexpected illness and injury, then increasing health costs stimulating the demand for broader, first-dollar coverages which is turn generate the provision of more complete, technical, and expensive care.

Without any doubt, the cost of more and better health care is paid for ultimately by each and every American. However, the indirect taxes and employer paid group health insurance premiums in lieu of higher wages virtually eliminate the traditional effective and direct free market controls.

In 1940, direct payments by individuals accounted for 82 percent of personal health care expenditures. In 1974, only 35 percent of health expenses were paid directly by consumers.

No one seriously challenges the role of health insurance to spread the risk of high cost, unexpected medical care.

While health insurance in itself is an inflationary factor, Government provided benefits further remove the controls inherent in a free market economy one additional step.

The experience of Government programs such as medicare and medicaid should underscore for you the cost escalating problems inherent in any new Government health benefit programs.

THE NAIC MODEL HEALTH CARE COST CONTAINMENT PROVISIONS

In advocating comprehensive health insurance, three approaches to controlling health care costs are possible either separately or in combination with each other:

(1) Repsonsibility for controlling cost increases for health care service can be placed on Government. This requires the imposition of direct Government cost control regulation.

(2) Responsibility for controlling cost increases for health care services can be placed, at least in part, on the consumer through such techniques as deductibles and coinsurance.

On the one hand, to the extent these techniques are effective in inducing persons to refrain from seeking health care services, financial barriers could be erected to obtain not only unneeded but perhaps also needed medical care.

Thus, the design of the deductibles should be carefully considered. On the other hand, after the patient seeks the service of a physician, typically, the physician becomes the primary determinant of demand to the extent the patient relies on the physician.

The greater the reliance, the lesser the impact of the deductibles and coinsurance on utilization.

(3) Responsibility for controlling the costs for health care services can be placed, at least in part, on the providers by restructuring the delivery system—for example, HMO's and/or the payment system—in a way that providers share in the risk of cost of services—for example, nonpayment for overutilization.

The major caveat to this alternative is the need to detect and prevent potential deterioration in the quality of care and any adverse impact on the supply of needed health care services.

This model bill utilizes a combination of these approaches. Commencing with section 10, a Health Care Commission is created with authority to implement both cost and quality control programs through rate review, certificate of need, and peer and utilization review mechanisms thereby vesting a primary responsibility on Government to control health care costs. The deductible and variable copayment requirements in qualified comprehensive health insurance provides a meaningful means to induce consumer cost conscious decisionmaking.

However, until such coverage replaces a significant portion of existing insurance, its cost impact will be relatively small.

This act does little to immediately restructure the payment systems to create health care provider cost conscious incentives in their decisionmaking in the absence of continuing Government oversight and sanctions. However, the framework to implement such incentives when developed and deemed feasible is established in section 14. Until consumer and provider cost incentives become effective, considerable reliance must be placed on direct Government cost and control measures.

Maintaining and improving the quality of health care is always a major objective when considering the health care delivery system, especially since the market mechanism currently does not function to assure adequate quality. The problem becomes acute when increased insurance coverage results in demand for health care services accelerating faster than supply. The danger of deteriorating quality becomes even more acute if effective cost controls are applied in a manner to induce the providers of health care to cut back on various needed and sometimes expensive or time-consuming services.

The provisions of the bill can be broadly discussed in three parts:

(1) Consumer cost-consciousness is maintained through a mandatory deductible and variable copayment provision which places a limit

on out-of-pocket expense. An optional triple deductible provision is included in the model for those States that prefer a catastrophic insurance system as opposed to a comprehensive one. Section 6–C.

(2) An approval system of rating health coverage outlined in the bill assures the reasonable relationship of cost to coverage section 8.

(3) And commencing with section 10, a State health care commission or health planning agency as designated under Public Law 93–641 is created with authority to implement both cost and quality control provisions of the bill.

This commission would be responsible for:

(*a*) Uniform cost accounting for all health care facilities (section 11);

(*b*) Rate review and approval for all health care facilities (section 12);

(*c*) Capital expenditure and service review (section 13);

(*d*) Approval of plans which health care facilities are required to develop to assure the quality and medical necessity of care and charges (section 14);

(*e*) Receiving reports by health insurance carriers regarding changes in provider fees (section 14–E) and,

(*f*) Assessing the need for cost control measures in the medical supply industry (section 15).

These provisions were designed to provide consumer cost-consciousness for health services, assurance of the reasonable relationship between insurance rates and benefits provided in both the comprehensive and catastrophic insurance options and review and control of health care cost factors.

CONCLUSION

The provisions of the model bill relating to cost containment which we have presented are similar to provisions now in effect in Connecticut, as well as some of those in Maryland, New Jersey, and Washington.

Exhibit I, comparing increases in the average hospital cost per diem for the period 1969 through 1974 for the States of Connecticut, Massachusetts, New York, New Jersey and Pennsylvania with the Nation as a whole, supports the point that only legislation applying to all sources of patient income can effectively contain the rate of escalation in hospital costs.

During this period, Massachusetts, New Jersey, and New York with fragmented, and thus ineffective controls, generally followed the pattern of escalation established nationwide. The much-publicized New York statute, which is limited in its authority to the rates paid by medicaid and Blue Cross plans, has not only failed to restrain the rate of escalation in average cost per diem since the law became effective in 1970, exhibit 1, but may have provided an incentive for increased utilization of inpatient facilities. The latter is evidenced by a 4.3 percent rise in hospital utilization in New York State since enactment of the statute, compared with a 1.5-percent increase nationwide.

Because the average cost per diem is derived by dividing the total expenses of the institutions involved by the number of inpatient days of care delivered, the New York experience, in terms of the average increase in cost per diem, would be even higher than the figure states if the New York utilization experience had paralleled the nationwide average.

The escalation rate in average cost per diem in all of the neighboring States (Massachusetts, New Jersey, New York and Pennsylvania) where there is no external review and approval of increases in hospital charges generally followed the national pattern.

The Connecticut experience is significant because the rate of escalation in that State similarly paralleled or slightly exceeded the nationwide experience through 1973, the year the Connecticut legislature established the Commission on Hospitals and Health Care.

Thus, in 1974, Connecticut was the only State (the Maryland statute did not become effective until July 1, 1974) requiring hospitals to justify increases in charges. Although controls had already been established over Blue Cross, medicare and medicaid payments, the action by the Connecticut legislature provided the first opportunity to see how hospital costs behave when future increases must be justified for all sources of patient income.

Exhibit II illustrates the impact of the Commission's activities on hospital price—charges—increases paid by private sector patients. In each of the 3 years shown on the chart, the price increase in Connecticut has been more than 40 percent lower than the corresponding increase in hospital charges nationwide. The cumulative impact of this savings is estimated in excess of $30 million for the 3 year period involved.

While the Commission, because of limited staff and budget, has not yet proven its capabilities to evaluate hospital revenue due to volume increases (utilization and intensity of service), the fact that the general hospital utilization figures have been below the national average suggests a continued reduction in the average cost per diem of all patients for fiscal years 1974–75 and 1975–76, thus corresponding to the first year experience of the Commission's operation in which the increase in the average cost per diem was more than 20 percent below the national average.

The impact of the Commission's efforts may be summarized as follows:

(1) Prior to the enactment of the legislation, the rate of escalation in hospital per diem costs in Connecticut tracked very closely with the nationwide experience;

(2) Price increases—charges—for the private sector patient were reduced more than 40 percent below the national average in each of the 3 years in which the Commission has been in operation as indicated in the following table:

[In percent]

	Connecticut	United States
Fiscal year:		
1973–74	6.1	11.8
1974–75	8.3	13.9
1975–76	9.6	[1] 14.0

---

[1] Estimated.

(3) The restraint in the rate of increase in hospital charges is reflected in the reduction shown in the rate of increase in the average cost per diem for all patients—8.9 percent in 1973–74 was contrasted with an 11.6-percent increase in the United States;

(4) The Commission's authority to approve increases in hospital revenue due to volume increases, even though it has not yet been fully implemented, is an essential part of effective cost control;

(5) The law provides flexibility both for the Commission in controlling the volume of budgets to be reviewed in each fiscal year and for individual hospitals in obtaining revenue increases which reflect the individual institution's needs. For example, the Commission in fiscal year 1974–75 established an 8-percent passthrough price increase, and thus cut the volume of individual budget submissions in half. However, for fiscal year 1975–76 all budgets were subject to review. Similarly, while the average price increases approved were 8.3 percent and 9.6 percent for each of the years involved, individual hospital price increases varied from 4 percent to 26.5 percent;

(6) Progress could not have been achieved without hospital cooperation in meeting the challenge of the new law, along with reciprocal government action in gradually phasing in the process;

(7) The close correlation between the prospective budget increases approved each year and the actual experience of the hospitals enables the various sources of financing, both governmental and private, to project their future costs with greater reliability.

The absence of lawsuits challenging the authority or work of the Commission indicates that the above has been achieved in a climate in which the hospitals have been able to generate adequate income to provide needed services and to expand such services on a basis consistent with community needs.

There are still a number of unresolved problems with which the Commission will have to come to grips. The experience to date, however, effectively challenges the two most frequent criticisms of hospital rate regulation: "It has not worked" and "the rate of escalation is due entirely to inflationary forces beyond the control of the institution."

While the Commission does not review the Blue Cross reimbursement formula, it impacts the charge ceiling applicable under the agreement and the rate of escalation in total costs.

One apparent result has been an increase in the number of hospitals being paid charges by Blue Cross—from 12 in 1972–73 to 17 in 1973–74.

Federal and State controls under medicare and medicaid have been totally ineffective in impacting on the rate of cost escalation under these programs. Conversely, the Connecticut Commission, while unable as yet to directly include medicare and medicaid costs, has reduced the rate of escalation in charges paid by the private sector, and indirectly has impacted on the rate of escalation of medicare and medicaid.

The Department of Health, Education, and Welfare and the Congress have expressed increasing interest in experimentation with prospective rate-review systems for institutional services. However, experience to date has confirmed the belief that such review systems are likely to be ineffective unless applied to the care rendered all patients.

If hospital support and acceptance of a State-administered rate regulation system is to be realized, hospitals are entitled to the assurance that such regulations will simplify rather than complicate the present process.

An essential element of this system is the full participation of the Federal Government in the State rate review process, that is, accepting the responsibility to reimburse the institutions for their full financial requirements and supporting the judgments of the State commission.

The State Health Care Commission we advocate has the responsibility for implementing uniform cost accounting in hospitals, advocating professional standards review organizations which are mandated for beneficiaries of governmental programs by Public Law 92–603, and approving health facility capital expenditures. These are all major steps in stemming health care cost inflation.

However, unless they are applied to all sectors of reimbursement for hospital cost, they will again only shift the burden to the private sector. Reductions in the payment of hospital services under medicare does not address cost escalation.

I believe that medicare reimbursement should be made at rates approved by a State Health Care Commission. These rates would assure the reasonableness of the charge in much the same manner as State insurance regulation today.

Realistically, the cost of health care will remain high. The redefinition of medicare reimbursement, State adoption of comprehensive health insurance and implementation of cost containment provisions can only reduce the acceleration rate of these costs. As commissioners of insurance in the States, we propose to work hand-in-hand with the Federal Government by advocating before our various legislatures, State hospital rate and capital expenditure approval as a prerequisite to insurance third-party reimbursement. We strongly believe this prerequisite should also apply to medicare reimbursement.

Thank you for your attention. I will be happy to answer any questions you have concerning my comments.

[Attachment to the statement follows:]

EXHIBIT I

PERCENTAGE INCREASE IN AVERAGE HOSPITAL COST PER DIEM

	1969–71 [1]	1971–72	1972–73	1973–74
Connecticut	33.3	12.5	11.2	[2] 8.9
Massachusetts	36.0	11.6	9.7	14.2
New Jersey	29.6	10.2	12.7	11.0
New York	30.4	14.3	9.1	9.9
Pennsylvania	34.8	14.5	10.2	10.6
United States	32.0	13.8	9.0	11.6

[1] Total increase over the 2-yr period.

[2] Percentage figure for 1st year Connecticut Commission operative.

SOURCES

"Selected Community Hospital and Demographic Statistics, Statistics by Census Division and State, 1974," Department of Special Research Studies, American Hospital Association, October 1975.

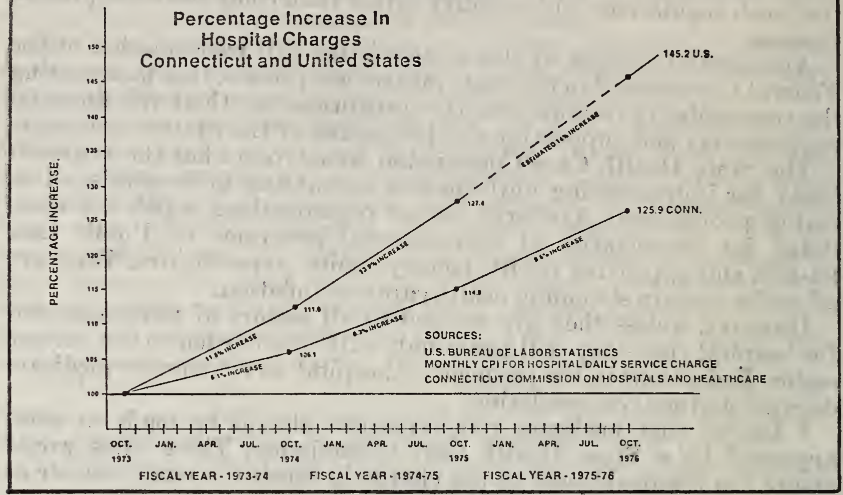
"Selected Community Hospital and Demographic Statistics, 1973" Bureau of Research Services, American Hospital Association, November 1974.

"Hospital Statistics," American Hospital Association.

"Hospital Statistics, 1971," American Hospital Association, Aug. 1, 1972.

"Hospitals, Journal of the American Hospital Association," guide issue, American Hospita lAssociation, Aug. 1 1970.

EXHIBIT II



SOURCES:
U.S. BUREAU OF LABOR STATISTICS
MONTHLY CPI FOR HOSPITAL DAILY SERVICE CHARGE
CONNECTICUT COMMISSION ON HOSPITALS AND HEALTHCARE

Mr. Rostenkowski. Thank you, Mr. Rottman and Mr. Hawkins.

The subcommittee has no questions.

The subcommittee will recess until 1:45 this afternoon.

[Whereupon, at 12:15 p.m., the subcommittee recessed, to reconvene at 1:45 p.m.]

Afternoon Session

Mr. Rostenkowski. The committee will resume its sitting.

Mr. Olson, would you take the witness chair, please.

STATEMENT OF MANCUR OLSON, VICE CHAIRMAN, MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

Mr. Rostenkowski. Please identify yourself and proceed.

Mr. Olson. Thank you, Mr. Chairman. My name is Mancur Olson. I am vice chairman of the Health Services Cost Review Commission of the State of Maryland and professor of economics at the University of Maryland.

The State of Maryland has been mentioned several times, Mr. Chairman, in the testimony today, and I believe that that is because in our State the method of commission regulation of rates has been carried further, perhaps, than in other States.

I would like, sir, to share our experience with you on the effects of rate regulation in Maryland and the implications of this for the Federal Government and other States.

I would say that the single most important thing to emerge from our experience is that the major causes of the escalating hospital costs are the reimbursement methods of medicare and in many States of medicaid and Blue Cross as well.

This point, of course, is not a new one and has been learned in other ways and in other States as well.

It has not, however, always been clear that the conventional arguments for reimbursement through medicare and various other third-party payers raise costs in two distinct ways. First, they raise the price or cost of whatever services are provided and, second, they give an incentive for the provision of more services than would otherwise be provided and often more services than are in fact needed.

On the first effect—the effect of the reimbursement schemes on the price charged for services—we have in Maryland some interesting examples. For instance, we have a pathologist in the State of Maryland whose earnings last year, as you may have noticed also from the newspapers, were found by our commission to be about $430,000. There are other examples that are also rather striking.

Now, I submit, Mr. Chairman, that the reason for that is not any conviction that you need give someone that much money to avoid privation or that that amount is necessary to induce people to show up for work. The explanation, I believe, is rather that most of the costs of these services were costs that were borne automatically by medicare, medicaid and Blue Cross; and, thus, the hospitals did not need to keep down the price.

We have found in Maryland in some cases that the remuneration of pathologists, radiologists, and anesthesiologists, the doctors hired by hospitals, sometimes has reached very high levels. It is very hard to explain until one remembers that hospitals often don't really have to worry that much about getting reimbursed for these payments, however princely they might be.

We have also found that this explanation helps account for the wages of nonmedical employees, or employees other than physicians. In the Nation as a whole in the last 2 years hospital salaries have risen 22 percent, which is well in excess of the average for the rest of the economy.

I would again allege, Mr. Chairman, that very probably a reason for this is the reimbursement methods which have kept hospital administrations from taking a vigorous stand against excessive wage demands.

There is also a similar effect showing up in the demand for hospital supplies. There has been a 25- to 30-percent increase in radiology film costs in the last year.

The second of the two ways I mentioned in which the reimbursement methods seem to me to add to cost is by increasing the quantities of services that hospitals provide. Here we suggest the hypothesis that the length of stay is in some hospitals in some cases longer than it would otherwise be because the longer the patient stays, the more money the hospital gets. I know there is PSRO and so on, but it seems to me at least in many cases this has not been sufficient. Again, because of the logic of the cost-reimbursement formulas, some hospitals seem to have provided excessive amounts of ancillary services.

So, we need then, I believe, changes in reimbursement schemes to limit the amount of services provided as well as the prices of those services.

Now if we have had as I believe, Mr. Chairman, excessive increases in hospital costs, then you may ask, how does rate regulation of the type we have had in Maryland fit into the picture?

I would say it is too early, much too early to conclude as some have that we need to go the route of State regulation of hospital rates. In our State, our commission has definitely lowered hospital costs and lowered them significantly.

However, I would not conclude because of this experience that it would necessarily be desirable over the long run and over the whole country to have commission regulation of rates. We should have more experiments along this line and it might prove in the long run that this is good.

There are two main reasons we should keep an open mind as to whether the commissions of the kind I represent are the way to go. First, the public utility rate regulation in this country, and other countries for that matter, does not have a terribly happy record. Industries like the railroads that have been regulated the longest are hardly the industries we hold up as examples of efficiency and innovation and I believe regulation has something to do with the lethargic histories of industries like that. There is a tendency for public utility regulation to introduce bureaucratic delays and monopolistic sinecures.

The second main reason, as I see it, why public utility regulation has not been exceptionally successful in other industries, is that again and again, the public utility commissions, the rate setting commissions become the patsies, the servants as it were, of the industry that is regulated. That is, of course, not a new point. It is a familiar one to students of public regulation but familiar as it is it seems it needs emphasis when others are advocating state rate regulation for the whole country.

Why is it that commissions often become captives of the industries they regulate? I think the main reason is the industry that is regulated is highly organized and thus able to present its case well and to lobby in the political system for favorable commission appointees and so on, whereas the people that pay the rates that are set are not usually organized and not so well represented in the political system. Though happily we have had no problems of the kind yet in Maryland, I believe there is a danger in the long run that ratesetting commissions might be taken over by the hospitals.

One inauspicious sign in Maryland is that our law more or less invites the Governor to appoint up to three Commission members from the industry being regulated. While it turns out that the hospital administrator—our astute and efficient chairman, Alvin Powers—and the two doctors who are on our commission have been zealous in keeping down hospital costs and have served with great idealism it is not by any means certain that future commissioners, whatever their occupations, will be equally zealous in protecting the public against higher hospital charges. So I would say again it is too early to tell what will happen.

If the commission method should work well in the long run I would guess it would be because of one difference between the hospital industry and other industries that are subject to public utility regulation, and that difference is that in the hospital case there is some organization of the payers, the third-party payers, medicare, medicaid, Blue Cross, and the commercial insurance companies. These are large and powerful institutions, and the last two are able to operate explicitly in the political realm. It is to be hoped they will operate on ratesetting commissions with the opposite bias from that which comes from the hospital. If there are two pressures which push in opposite directions and countervail one another, then ratesetting might work well. If ratesetting does work well in the long run, that will be the reason why.

What I think our experience in Maryland does already show for certain—one thing we can commend without being so tentative—is that we need changes in the incentive systems created by medicare and some other third-party payers.

It seems to me that the medicare type cost-reimbursement systems need to be changed in two ways:

First, we need prospective reimbursement. That again is not an original point with us or something that has emerged only from the experience of Maryland, but it seems to me to be a very important point. What we have seen in Maryland is that when we set rates prospectively as we now do, instead of retrospectively as has been customary, the hospitals do indeed have an incentive to keep costs down.

We have not in my personal opinion done quite as well as we might have done in pointing out to hospitals that if they succeed in coming in under budget, they will be able to keep some part of the savings, but I believe we will get that message across with increasing clarity as time goes on and the effects of this, already favorable, will become increasingly so in the future.

A second thing that is needed besides prospective reimbursement in order to improve incentives is that we need to takeaway those features of the current reimbursement schemes which encourage the provision of too much service which, as I pointed out earlier, is a distinct thing from the price of the service itself.

What we are starting to do in Maryland is rewarding hospitals not by the services provided to the patient but per admission. That is to say, the ultimate earnings of a hospital are calculated in terms of the admissions to the hospital. This means that if the hosptial keeps the patient in the hospital longer than it would have done in the past, it gets no extra revenue from this over the long run. This is because we automatically cut its prices in the next period if its average level of services per admission has increased.

Another part of the problem is ancillary services. These are becoming proportionately more important as time goes on. We found them a particular problem in the State of Maryland.

However, if hospitals are rewarded on average by patients admited rather than in terms of the processes they go through and the services they provide, then they no longer have an incentive to provide additional and sometimes unnecessary ancillary services. The hospital, in other words, has been in the past in a situation where, if it got the average-cost price of an ancillary service and it had already bought the equipment needed to provide that service, it had an incentive to offer that service to additional patients, to encourage doctors to give additional tests, and so on, and on these it made a profit.

However, under the scheme which we are starting in Maryland, that incentive will disappear.

Another thing that needs to be added is a special incentive for preadmission testing. It is usually cheaper to give tests to patients before they enter a hospital, so they don't have to stay in the hospital at high cost for a time just to get these tests. We shall particularly reward hospitals in Maryland for using preadmission tests.

In the long run, when we can get better data on the case mix each hospital has, we intend to go in Maryland to the practice of rewarding hospitals in terms of the different cases that they handle. That is to say, the long-run goal our Commission is working toward is to pay hospitals different amounts for the different types of cases that they take on, so that a hospital that takes in very complicated cases can be paid more than one that takes in simpler cases and we don't need to have the rule of thumb that hospitals are rewarded on the basis of admissions.

Now, Mr. Chairman, if I might add one further point, we have just gotten permission from medicare to apply our system in the State of Maryland to medicare for an experimental period. This hasn't been easy to arrange. As you know, in the past, the cost reimbursement scheme of medicare and in our State also of Blue Cross and medicaid has meant that the cost of bad debts has fallen on those who have paid their own bills or who were commercially insured. Thus there has been understandably a concern that if medicare paid our rates, which are rates which apportion the cost of bad debts equitably over all payers, then medicare payments would go up.

So what our staff at the Health Services Cost Review Commission has done is work out a procedure whereby it would be possible for medicare to tell, if they pay our rates, which include something for bad debts, whether what they end up paying would be less than they would have paid had they stayed under the old system. In other words, our staff has worked out a simple procedure for calculating in an inflationary world how much medicare payments would have gone up under the old system. What this will enable us to do, and medicare to do, is to determine whether or not, in the experimental period when our system is applied, we are able to keep costs down enough so that medicare payments will be less under our system than they would otherwise have been even though under our system medicare will be paying its share of bad debts and thus lessening the charges to other users.

This system was worked out by our superb staff headed and selected by Dr. Harold Cohen. The main authors of this procedure, and of the prepared testimony I submitted are Dr. John Cook and Dr. Graham Atkinson. Would be thankful, sir, if you would be willing to put all of this into the record as a supplement to my testimony.

Mr. ROSTENKOWSKI. It is so ordered.

[The prepared statement and supplement follow:]

STATEMENT OF MANCUR OLSON, VICE CHAIRMAN, MARYLAND HEALTH SERVICES COST REVIEW COMMISSION

ISSUE I: REASONS FOR HOSPITAL COST INFLATION

One of the most frequently cited, and probably the most important reason for the excessive rate of inflation in health care, is the method by which Medicare and Medicaid reimburse hospitals. This reimbursement method has two basic shortcomings. The first is that it bases the amount of reimbursement on what the hospital actually spends rather than on the amount it was reasonable to have spent. This essentially removes all economic incentives to provide health care efficiently.

The second shortcoming is that Medicare and Medicaid pay on the basis of the amount of service provided to each patient rather than on the amount that it would be reasonable to provide. Thus, there are no economic incentives to perform pre-admission testing, reduce inpatient length of stay or eliminate unnecessary or marginal ancillary services.

The following paragraphs indicate some of the specific ways in which Medicare reimbursement has promoted excessive hospital costs.

Approximately two thirds of a hospital's expenses are associated with wage, salary and fringe benefit costs. Thus, it is natural to examine the effect of Medicare reimbursement on hospital personnel expense. Martin Feldstein's short book, "The Rising Costs of Hospital Care" sets forth a great deal of pertinent data on this subject. The conclusions of his analysis, which were based on statistical information gathered in the late 1960's, include the finding that by 1970 hospital workers were frequently paid more than comparable workers in business and industry. The Medicare and Blue Cross reimbursement systems had signaled the decline of normal market forces in the determination, by the Hospital Industry, of appropriate salary levels. The accelerated trend in hospital wage rates was no doubt abated by the Cost of Living Council. Their demise in April 1974, however, introduced yet another round of inflationary wage increases in the Hospital Industry. The Bureau of Labor Statistics report concerning the average hourly wage rates for nonsupervisory hospital workers reflects a 14.7% increase for the period June 1974 through June 1975. Estimates of the same statistic for the subsequent year indicate a 6.4% rate of increase. This moderated inflation rate is due largely to the nature of a number of Union contracts which will expire this year. Despite this moderation salaries in the Hospital Industry have risen nearly 22% over the last two years, which is well in excess of what an economy marked by high unemployment requires and certainly more than the amounts received by comparable employees in business and industry.

It is clear that a sound regulatory model must prescribe, or create incentives that will result in, reasonable aggregate increases for salary, wage and fringe benefit expense. These increases might well be tied to the rate of change in salaries of comparable employees in business and industry or to regional or national Consumer Price Indices.

Supply costs make up the second most important cost category in the Hospital Industry. Here again, the lack of market forces and the impact of Medicare's reimbursement formula has resulted in excessive increases in costs. Hospital supplies may be regarded as falling into two categories, those which are peculiar to the Hospital Industry and those which are required by a large number of industries. Radiological film represents the first category, food and linen the second. For the most part, supply inflation in the second category is not excessive because market forces outside of the Hospital Industry hold prices down. On the other hand, medical supplies, pharmaceuticals, radiology and laboratory supplies exhibit alarming inflation rates. For example, radiology film costs increased between 25 and 30% in fiscal year 1976. Pharmaceuticals and medical supply costs increased in excess of 11%. Many of these items are provided by monopolies or oligopolies, whose influence and power are outside the control of any particular institution. As a result, a clear objective of a rational and efficacious regulatory model is the control and limitation of the usage of such supplies. This is tantamount to the elimination of unnecessary or marginal ancillary services.

The importance of limiting ancillary usage cannot be overstated. Ancillary services continue each year to account for a greater proportion of the health care dollar. At the same time there is little evidence that such services have a demonstrable cost benefit or even a significant impact on the overall health status of Public.

A third reason for the excessive rate of inflation in health care costs relates to unnecessary or marginal days of hospital care. In part, this is stimulated by the fee for service method of paying for physician services. Not only does this system encourage unnecessary admissions, particularly in surgery, it also fosters unnecessarily long hospital stays. While the PSRO program might well be expected to offer some disincentives to such practices, it would clearly be appropriate to incorporate into the reimbursement system incentives for reducing lengths of stay, limiting unnecessary admissions and encouraging pre-admission testing programs.

The proposal outlined in the subsequent paragraphs is predicated on the need to address the inflationary practices cited above. Let us turn, however, to an analysis of the review procedures currently in effect under the Medicare program.

ISSUE IV: ALTERNATIVE APPROACHES TO SETTING PROSPECTIVE RATES

The problem of developing a reasonable methodology for regulating hospital expenditures is decidedly complex. Nevertheless, there are certain basic concepts, derived largely from economic principles, which should be introduced in the regulatory method at the earliest possible time. The introduction of these concepts may, in the judgment of the Commission, be made with a limited period of phase in.

Two conceptual changes should be made as soon as practicable in the Medicare reimbursement and review systems. The first change is to shift to a prospective rate setting system. The second is to modify the payment method so as to provide clear incentives for eliminating unnecessary or marginal services. An outline of a suggested methodology for a prospective rate setting system is provided in a subsequent section. The purpose of the paragraphs which follow is to describe a suggested payment system for Medicare.

The importance of the conceptual structure of the payment system cannot be overstated. The payment structure should, in and of itself, introduce fundamental cost savings incentives. In this regard, a clear distinction must be drawn between processes and results. Laboratory testing, routine nursing care and surgery are processes. The well patient is, one hopes, the result. It is a self-evident economic principle that payment must be related to results if the payment system is to be rational and effective. The current Medicare system does not attend to this principal but rather reimburses hospitals on the basis of processes performed. This reimbursement system, coupled with the review procedures applicable to daily patient care, have the property of rewarding high utilization of nursing units, not efficient and effective health care delivery. Similarly, the open ended reimbursement for ancillary services exacerbates the proliferation of unnecessary or marginal diagnostic and therapeutic processes. What is required is a payment system which pays not for processes but for results.

A great deal of research has been carried out on the subject of measuring hospital output. For the most part, this research is of very limited value, primarily because there has not been sufficient information on which to base such studies. For impatient services, most observers of the hospital industry would suggest that output should be measured in terms of the number of patients admitted and the case mix or severity of illness of such individuals. It is clear that once a sick patient is admitted, the effectiveness of the hospital must be weighed in terms of whether or not the individual's health is improved or restored. The above observations suggest that the best simple proxy measure of hospital inpatient services is the number of patients served. This measure should, therefore, be used in the short term as the basis of Medicare reimbursement. It is of interest to note that this idea is consistent with the concepts developed by the Cost of Living Council under Phase IV.

In the long term, hospital admissions should be weighted according to discharge diagnoses, age, the existence of multiple diagnoses and other such factors as are determined to be the best measures of intensity of illness. Adjustments may then be made in a systematic and rational manner in accordance with changes in the burden of illness brought to the institution.

The essential idea of the payment system that will be outlined subsequently is to extrapolate the cost per admission as submitted on audited Medicare reports and to reimburse hospitals for inpatient services on the basis of Medicare admissions. For outpatient services hospitals would be paid as they are paid now. Let us consider some of the incentives inherent in such a payment system:

(*1*) *Length of Stay*

Since the hospital is neither being paid nor reviewed according to the number of days of care rendered, there is no incentive to maintain patients in the hospital unnecessarily. In fact, as hospitals are paid the same amount, independent of whether or not an individual is kept in the hospital for a long period, there is a clear incentive to shorten lengths of stay. In this way, PSRO effectiveness becomes consistent with the financial incentives of the reimbursement system.

(*2*) *Ancillary Services*

Since the hospital would not be paid on the basis of processes performed, there is a clear incentive to eliminate marginal or unnecessary ancillary usage.

(*3*) *Pre-Admission Testing*

Since such testing would be done on an out-patient basis, the attendant costs would be offset through the reimbursement system for outpatient services. Thus, pre-admission testing would be paid for directly and a clear incentive established for this less expensive method of health care delivery.

(*4*) *Admissions*

In this case the apparent incentives of the system are not favorable. First, there is a clear incentive to increase admissions. Moreover, there is an additional incentive to increase the proportion of relatively simple admissions. These shortcomings will be addressed in the next paragraph.

There are four ways in which one might guard against the problem of increasing the proportion of unnecessary or marginal admissions. First, the PSRO programs might be charged with the responsibility of determining whether or not an admission was unnecessary. No reimbursement would be made for unnecessary admissions. Second, the Minimum Basic Discharge Abstract Set could be used to evaluate changes in the Hospital's Case Mix. In particular, once a system of weights has been developed for discharge diagnoses, the information reported to the PSRO groups could be used to retroactively adjust the payment rate per admission in accordance with variations in case mix. Third, retroactive adjustments should be made for increases or decreases in the number of admissions. In particular, if the total number of admissions increases, a retroactive adjustment should be made which accounts for the fact that the hospital's fixed costs will have been distributed over a greater number of patients. Finally, if it is decided that the three methods outlined above are not adequate, one might limit reimbursement to the lower of the amount generated by the current system and the one being proposed. This alternative, however, is not recommended since it eliminates virtually all of the positive incentives to reduce costs.

PROJECTING MEDICARE COSTS TO COMPENSATE FOR INFLATION, NEW PROGRAMS, ETC.

The purpose of this paper is to describe a method whereby the cost per admission for Medicare in one year (which we shall call the base year) can be inflated to give a reasonable limit on the cost per admission in a subsequent year (which will be referred to as the current year). The adjustment allows for inflation, new programs, CHP approved new projects and increases in malpractice insurance and pension costs. Other reasonable cost increases, as specified by the Medicare commissioner, may be allowed on appeal by the hospital.

The first step is to determine the extent to which inflation is increasing hospital costs.

CALCULATION OF THE EFFECT OF INFLATION

For the purposes of calculating the effect of inflation on hospital costs, the costs are broken down into four categories: (1) Salaries, (2) Supplies and Contracted Services, (3) food and (4) depreciation and interest. Separate inflation indices will be calculated for each of these four categories. These indices will then be combined with weighing factors which are the proportion that the costs within a category bear to the total costs.

This gives an overall hospital inflation factor. The separate inflation indices are described below.

(1) *Salaries*

The inflation allowance suggested for salaries is the average percentage increase in wages of service industry workers. The indices should be for the area in which the hospital is situated rather than the national indices.

(2) *Supplies and Contracted Services*

The calculation of the inflation index for hospital supplies and contracted services is fairly complicated. It is described in detail in Appendix I. The basic idea is that the universe of hospital supplies and contracted services is subdivided into fifteen categories. The first fourteen of these categories are fairly homogeneous and the fifteenth is a catch all containing all the items not covered in the first fourteen. Inflation indices for the first fourteen categories are determined. In most cases these indices are constructed from indices available from the Bureau of Labor Statistics, but in some cases there is no readily available statistic which approximates the rate of increase in the category. For these subcategories the actual cost experience of a sample of hospitals will be used to determine the inflation factor. A weighted average of the fourteen inflation indices is taken, the weightings being the proportion of the total cost of the items in the fourteen categories which are made up of items in the particular category. This average is both the estimate for the inflation in the fifteenth category and the estimate of the inflation factor for the entire supplies and contracted services costs.

(3) *Food*

The inflation index for food is taken to be the average of the increase in the food component of the consumer and wholesale price indices.

(4) Depreciation and Interest

The inflation monitor should be the actual experienced rate of inflation in capital expenses as set forth in the Medicare reports.

Worksheet II has been prepared to provide a standard format in which to perform the calculations involved in the process just described. Worksheet III enables one to calculate the effect of unavoidable increases such as increases in workmen's compensation, pension costs, etcetera. The figure determined thereon is posted to Worksheet II. The overall inflation in the hospital's total costs can then be determined. This inflation factor is then posted to worksheet I. This is the worksheet used to calculate the cap on the average cost per admission. The total cost attributable to Medicare inpatients is inflated, adjusted for new programs, then adjusted for new services requiring CHP approval. The resulting total is divided by the projected number of admissions to obtain the projected cost per admission for Medicare.

To illustrate the ideas outlined here we have worked an example.

The cost data used in this example was based upon the fiscal year 1975 Medicare Cost Report of the Johns Hopkins Hospital. To illustrate the flexibility of the method being proposed, the revenue cap per admission has been calculated for calendar year 1976. Thus the fiscal year 1975 cost data has been projected forward for 18 months. Because Medicare cost reports are not filed for several months following the close of the fiscal year, it may turn out that 18 month projections will be necessary in order to give hospitals proper advance notice of their expected reimbursement per admission. Once the reimbursement rate has been set, however, it would be well to periodically adjust it for reasonable inflation in factor costs rather than reverting to subsequent cost reports for rate adjustments. Thus, for example, if a hospital's reimbursement rate per admission as determined by extrapolating from an initial cost report were $2000 in calendar year 1975 and reasonable factor cost increases, including specific adjustments for malpractice and utilities totaled 10%, then the rate per admission for calendar 1976 should simply be set at $2,200, independent of the amount that might be obtained by extrapolating a subsequent cost report. Reversion to a cost report as the basis for rate setting might be done every third year. In this way, cost savings generated by the hospital in the first year would be repeated in subsequent years thereby increasing the cost savings incentives of the prospective reimbursement system.

In order to get an overview of the extrapolation procedure, let us begin with a general discussion of Worksheet I. The first column depicts the accumulated costs of each of the hospital's revenue centers. Physicians who are reimbursed under Part B of the Medicare Program have their salaries included in a separate line at the bottom of this worksheet. These physicians are an integral part of the hospital's operation and should not be exempted from the review procedure. The second column specifies the estimated rate of inflation in factor costs from fiscal year 1975 to calendar year 1976.

It has been assumed that Hopkins has instituted one new program in calendar year 1976 which was mandated by the Government. This is a PSRO program costing $100,000. The costs of this program have been allocated throughout the hospital revenue centers. This allocation is set forth in column 3. Column 4 is simply the sum of columns 2 and 3.

In calendar year 1976 Hopkins began or expanded programs which had recently received CHP approval. A program in radiation therapy commenced in 1976 and an infant special care unit, which was operational in 1975, was expected to experience substantially increased volumes this year. The cost of these programs have been included in accordance with the hospital's budget. Adjustments would be made if a financial audit discloses substantial differences between budgeted and actual expenses. The costs of these programs have been included in column 5. Column 6 is simply the sum of columns 4 and 5.

Columns 7 and 8 represent a breakdown into percentages of total costs, the inpatient and outpatient portions of column 6. These percentages are based upon the distribution of costs between inpatients and outpatients developed on worksheet C of the Medicare report. Columns 9 and 10 are merely the result of multiplying column 6 by the inpatient and outpatient percentages in columns 7 and 8.

Column 11 represents the percentage of Medicare costs included in column 9. This percentage was derived by dividing amounts from Workksheet D of the Medicare cost report by Worksheet C, Column 3. Column 12, then, is the result of multiplying column 11 by column 9. The total costs of treating inpatient medicare beneficiaries is then specified at the bottom of column 12. This amount, divided by Medicare admissions, is the recommended payment rate per Medicare admission.

WORKSHEET I

	Total costs base year[1]	Inflation 1.1712	New programs	Col. 2 plus col. 3	New program CHP appropriation	Col. 4 plus col. 5	Percent		Costs		Percent of medical inpatient	Medicare inpatient costs
							Inpatient	Outpatient	Inpatient	Outpatient		
Ancillaries:												
Operating room	4,865.5	5,698.5	6.8	5,705.3		5,705.3	91.6	8.4	5,226.1	479.2	17.0	888.4
Labor and delivery	832.6	975.1	1.2	976.3		976.3	98.6	1.4	962.6	13.7		
Anesthesiology	1,672.3	1,958.6	2.4	1,961.0		1,961.0	95.3	4.7	1,868.8	92.2	15.8	295.3
Radiology:												
Diagnostic	4,345.0	5,088.9	6.1	5,095.0		5,095.0	60.6	39.4	3,087.6	2,007.4		
Therapeutic	552.7	647.3	.8	648.1	301.9	950.0	19.9	80.1	189.1	760.9	25.0	966.0
Nuclear medicine	679.4	795.7	1.0	796.7		796.7	73.7	26.3	587.2	209.5		
Laboratory	9,110.1	10,669.7	12.8	10,682.5		10,682.5	69.3	30.7	7,403.0	3,279.5	24.3	1,798.9
Blood	100.7	117.9	.1	118.0		118.0	92.5	7.5	109.2	8.8	28.8	31.5
Intravenous therapy	847.5	992.6	1.2	993.8		993.8	97.0	3.0	964.0	29.8	32.7	315.2
Inhalation therapy	296.7	347.5	.4	347.9		347.9	100.0		347.9		33.7	117.2
Physical therapy	564.6	661.3	.8	662.1		662.1	69.9	30.1	462.8	199.3	27.7	128.2
EKG	454.6	532.4	.6	533.0		533.0	63.9	36.1	340.6	192.4	24.3	82.8
EEG	214.3	251.0	.3	251.3		251.3	60.4	39.6	151.8	99.5	24.3	36.9
Medical supplies sold	2,588.4	3,031.5	3.6	3,035.1		3,035.1	95.8	4.2	2,907.6	127.5	32.7	950.8
Drugs sold	2,679.7	3,138.5	3.8	3,142.3		3,142.3	89.0	11.0	2,796.6	345.7	24.9	696.4
Renal dialysis	239.3	280.3	.6	280.9		280.9	88.6	11.4	248.9	32.0	58.0	144.4
Kidney acquisition	157.2	184.1		184.1		184.1	100.0		184.1		100.0	184.1
Inpatient:												
Adults and pediatrics	30,157.1	35,320.0	42.4	35,362.4		35,362.4	100.0		35,362.4			
ICU	2,636.7	3,088.1	3.7	3,091.8		3,091.8	100.0		3,091.8		18.4	7,414.6
Infant special care					1,172.0	1,172.0	100.0		1,172.0			
Nursery	494.1	578.7	.7	579.4		579.4	100.0		579.4			
Outpatient:												
Clinic and emergency room	7,230.1	8,467.9	10.2	8,478.1		8,478.1	4.7	95.3	398.5	8,079.6	18.1	72.1
Dietary	109.0	127.7	.2	127.9		127.9	28.9	71.1	37.0	90.9	30.3	11.2
Dental	208.6	244.3	.3	244.6		244.6	28.6	71.4	70.0	174.6	5.1	3.6
Other: pt. B—physicians	1,054.7	1,235.3		1,235.3		1,235.3	69.4	30.6	857.3	378.0	13.0	111.7
Total	72,090.9	84,432.9	100.0	84,532.9	1,473.9	86,006.8			69,406.3	16,600.5		14,249.3
Medicare admissions												5,461
Average charge per admission												2,609.28

---

[1] Worksheet B—col. 1.

WORKSHEET II

WORKSHEET TO CALCULATE OVERALL INFLATION FACTOR

Category	Base year cost	Percent total supply cont. ser.	Inflation factor	Projected cost	Combined (2) × (3)
1. Salaries, wages and fringe benefits (excluding physicians)	$44, 143, 761		16. 79	$51, 555, 498	
2. Physician expense	3, 542, 872		19. 00	4, 216, 017	
3. Supplies and contracted services	24, 333, 688		16. 43	28, 380, 380	
(i) Printing	917, 380	3. 77	11. 45		0. 43
(ii) Medical supplies	9, 212, 734	37. 86	17. 10		6. 47
(iii):					
Laundry	1, 272, 652	5. 23	10. 88		. 57
Glassware	228, 737	. 94	15. 42		. 14
Chemicals	469, 640	1. 93	17. 25		. 33
Films	1, 051, 215	4. 32	39. 75		1. 72
Gases	92, 468	. 38	26. 23		. 10
Blood	1, 060, 949	4. 36	29. 98		1. 31
Contracted	2, 151, 098	8. 84	13. 72		1. 21
Professional fees	540, 208	2. 22	10. 40		. 23
Insurance	296, 871	1. 22	13. 07		. 16
Telephone	919, 813	3. 78	6. 55		. 25
Utilities	2, 282, 500	9. 38	16. 14		1. 51
Food	1, 523, 289	6. 26	9. 86		. 62
(xv) Other	2, 314, 134	9. 51	16. 63		1. 58
4. Malpractice	792, 500			1, 122, 500	
5. Depreciation interest and leases	2, 932, 600			3, 113, 400	
Total	75, 745, 421			88, 387, 795	
Unusual cost increases				321, 800	
Overall total				88, 709, 595	
Overall inflation factor			17. 12		

WORKSHEET III.—WORKSHEET TO COMPUTE EFFECT OF GOVERNMENT MANDATED INCREASES IN COSTS

	Col. 1: Base year cost	Col. 2: Inflation factor	Col. 3: Combined total (col. 1× col. 2)	Col. 4: Budget	Difference: (col. 4—col. 3)
(1) ERISA	47, 100	16. 79	55, 000	265, 000	210, 000
(2) Workman's compensation	54, 800	16. 79	64, 000	175, 800	111, 800
(3) Other					
(4) Total					321, 800

Appendix I

INFLATION INDICES FOR HOSPITAL SUPPLIES

For the purposes of calculating inflation indices we subdivide the Supplies and Contracted Services into 15 subcategories. These sub-categories are listed in Appendix II. The inflation indices for each of the first 14 sub-categories are estimated by the methods described in this appendix. The fifteenth sub-category is a catch all, and its inflation rate is taken to be the average of the inflation rates for the preceding 14 sub-categories. The inflation rate for each of the first 14 sub-categories is estimated either from some easily obtainable proxies, such as subindices of the wholesale price index (WPI) for the main items involved in the category, or, if good proxies are not available, by estimating the inflation from price data obtained from a sample of hospitals.

(*1*) *Printing, office supplies, copying, postage*

The two proxies which are taken for this sub-category are (1) the change in the Bureau of Labor Statistics (BLS) hourly wage for all service workers, and (2) the WPI index change for bond paper. These two proxies are arbitrarily assigned weights of 0.75 and 0.25 respectively.

(2) *Medical, surgical, pharmaceutical and other supplies*

There is no readily available proxy to measure inflation in this category, so the inflation will be estimated from actual price data obtained from a sample of hospitals. A weighted purchase price index (PPI) of supplies actually purchased in these areas will be prepared. This PPI is developed using the difference between the last prices paid in the year for which inflation is being calculated and the last price paid in the previous year, and is based on a list of items from the central storeroom and central supply department which can be exactly identified from year to year. The weighting will be based on the volume used in the year for which the inflation rate is being calculated. Any items which are included in other sub-categories will not be included here.

(3) *Laundry, linen and uniforms*

Labor inputs are arbitrarily assigned a weight of 0.75. The index is taken as the BLS hourly wage index for all service workers. The proxy for materials is the WPI for cotton sheets, which is assigned a weight of 0.25.

(4) *Glassware*

The glassware category is adjusted using the WPI for all glass containers for the most recent WPI index period available.

(5) *Chemicals, solutions and lubricants*

This category is adjusted using the WPI for all chemicals.

(6) *Films and solutions*

This category is exclusively related to radiology. The inflation adjustment can be determined precisely because there are a small number of suppliers of films and solutions. The inflation index will, therefore, be determined from the contract rates negotiated between the hospitals in the sample and their suppliers.

(7) *Gases*

The proxy used for this category is the WPI for inorganic chemicals.

(8) *Blood, plasmanate and albumin*

The actual increase in costs experienced by a sample of hospitals is used for this category.

(9) *Contracted Services including, security, purchased clerical and laboratory services*

The BLS hourly wage index for all service employees is used as the proxy here.

(10) *Professional fees, accounting, legal fees, etc.*

The Consumer Price Index (CPI) for lawyer fees is used as the proxy for this category.

(11) *Insurance, excluding malpractice*

The CPI for insurance premiums is used as the proxy.

(12) *Telephone*

The CPI for telephone is the obvious proxy for this category.

(13) *Food*

The average increase in the food component of the consumer and wholesale price indices is taken as the inflation index.

(14) *Utilities*

The inflation rate in utility costs can be calculated precisely using the costs actually experienced by the hospital.

(15) *Other*

This category groups all miscellaneous other expenses and includes repair, maintenance, training, collection expenses and general administrative expenses. There is no suitable extrinsic proxy to cover all these items. Moreover, the actual hospital cost experience cannot be isolated, so the average increase over the other 14 categories is taken as the estimate for the inflation in this category.

APPENDIX II: LIST OF 15 SUB-CATEGORIES

1. Printing, office supplies, copying and postage.
2. Medical, surgical, pharmaceutical and other supplies.
3. Laundry, linen and uniforms.
4. Glassware.
5. Chemicals, solutions and lubricants.
6. Films and solutions.
7. Gases.
8. Blood, plasmanate and albumin.
9. Contracted services including security, purchased clerical, and laboratory services.
10. Professional fees, accounting, legal fees, etc.
11. Insurance, excluding malpractice.
12. Telephone.
13. Food.
14. Utilities.
15. Other.

Mr. ROSTENKOWSKI. This morning there was testimony by the Blue Cross people and they said incentives for efficiency could be provided through a retrospective reimbursement system without moving to prospective reimbursement systems.

Do you agree with that?

Mr. OLSON. No, absolutely not. Blue Cross as well as medicare and medicaid in Maryland have had retrospective reimbursement. One would see the typical hospital getting perhaps 85 percent of its revenue from these three parties which paid retrospectively and there was overspending to a serious degree.

Mr. ROSTENKOWSKI. Mr. Olson, setting up a budget for each individual hospital, wouldn't this really be quite expensive?

Mr. OLSON. We have not found it to be very expensive. For very, very small hospitals this could perhaps be a problem. We have been enjoined by our legislature to regulate nursing homes and some of the nursing homes are really small. So what we are doing is exempting very small nursing homes from the demanding parts of our record-keeping and budgeting system.

However, our observation is that the accounting staffs that hospitals already have in order to deal with the third-party payers they already deal with are sufficient with minor training and supplementation to put forth the budgets that we need. When they put forth these budgets, that enables them to run the hospital better so the hospital is probably money ahead putting forth the type of budget, and collecting the type of data that we demand.

Mr. ROSTENKOWSKI. Does the Maryland experience provide any guidance on what the relationship should be between health facilities planning and rate regulation or reimbursement for services?

Mr. OLSON. Yes; it does, Mr. Chairman. I don't know that we can claim in Maryland that we have always been successful in blocking the construction of redundant or lavish facilities. We worked very hard in our Commission to do that and I am happy to say that the health planning agencies are now working with us in this, and we are cooperating very nicely.

At the same time, the pressures for new facilities are often powerful and we cannot always promise success in blocking unnecessary facilities.

What we have done in a few cases is the following: Our Commission has said that if a facility was necessary, and if the facility was constructed economically, then we would put forth a statement that our Commission would approve such rates as were necessary with adequate volume to pay off the indebtedness that the hospital got into with this needed and economical facility.

That means that those hospitals that want to construct facilities which are not, in fact, necessary, or those hospitals which want to construct gold-plated facilities, are then put in the invidious position of not having gotten a statement from us that we will allow the rates needed to pay off the indebtedness they incur, and that tends to make the lenders uneasy and that tends to reduce the chances that the unnecessary or lavish facilities will be built.

Mr. ROSTENKOWSKI. Mr. Olson, granted that State ratesetting needs to be studied further, do you think medicare participation in State programs under circumstances similar to the one you have worked out in Maryland ought to be mandated now?

Mr. OLSON. Yes; I do, sir. That is not for all States, but mandated that medicare should do what they are beginning to do with us in some other States as well. I think that would be very useful.

Mr. ROSTENKOWSKI. Thank you, Mr. Olson.

Mr. OLSON. Thank you, sir.

[The following was subsequently supplied for the record:]

UNIVERSITY OF MARYLAND,
DEPARTMENT OF ECONOMICS,
College Park, August 4, 1976.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, Longworth House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROSTENKOWSKI: It is indeed fortunate that you are holding hearings on rising hospital costs and the role restrospective reimbursement has played in increasing them. I hope you will continue to give this important matter a high priority.

After my testimony you asked my judgment on the Blue Cross assertion that retrospective reimbursement was not a cause of inefficiency. In answering I neglected to point out that Blue Cross in some states has vested interest in maintaining the current system of retrospective reimbursement; under this system in some states they avoid paying any of the costs of bad debts and charity care, which costs are then all allocated to self-paying and commercially insured patients, with the result that Blue Cross has in these states a major advantage over its competitors. Blue Cross has been able to get this advantage in some states because of its size and bargaining power; if the system is legislatively changed, as it must be if prospective rate setting is to become general, Blue Cross may no longer enjoy this competitive advantage. It was certainly this concern about its competitive advantage that explained the initial Blue Cross opposition to prospective rate setting in Maryland. I'm glad to say that Blue Cross in Maryland is now more or less reconciled to a smaller "differential" or competitive advantage and is cooperating very well with our Commission.

Let me know if I can be of any help to you or your Subcommittee at any point in your work on this vital issue.

Sincerely,

MANCUR OLSON,
Vice Chairman,
Health Services Cost Review Commission.

U.S. House of Representatives,
Committee on Ways and Means,
Subcommittee on Oversight,
Washington, D.C., August 20, 1976.

Hon. Dan Rostenkowski,
Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives.

Dear Mr. Chairman: I would like to submit for inclusion in the August 3 hearing record on prospective reimbursement methods a letter which I received from the Maryland Hospital Commission in response to a number of questions which I posed to the Commission.

Thank you for your consideration of this request.

Sincerely,

Charles A. Vanik,
Chairman, Subcommittee on Oversight.

Enclosure.

July 7, 1976.

Dr. Harold Cohen,
Director, Maryland Health Services Cost Review Commission,
Baltimore, Md.

Dear Dr. Cohen: Reviewing your testimony concerning prospective reimbursement for hospital services, given on May 14, 1976, before the Subcommittee on Oversight, Committee on Ways and Means, I found a few areas that require clarification. Your further cooperation would be appreciated.

During your testimony (on page 9), you mentioned that since July 1, 1974, "hospital rates in Maryland, over the 22-month period, have increased at a fairly consistent annual rate of 7 percent," while costs have increased "at an annual rate of 9–10 percent." How have hospitals been able to continue to operate under such circumstances without going bankrupt? How do they make up for the 2–3 percent difference between hospital rates and costs?

At page 22 in the testimony, you discussed the suit that the American Hospital Association brought against your Commission in district court, challenging, primarily, your guidelines. If you could send me a copy of your brief in that case, it would be appreciated.

Another problem that you said you were having (p. 23) was that although Social Security helped contribute financially toward the development of your rate-setting methodology, they were not, and still are not, paying your rates. Why do they refuse to pay your rates?

Something else that I would like clarified is the uniform functional accounting system that you described at page 24. I would appreciate your sending me the data which you have for every hospital in Maryland concerning what management per equivalent in-patient-day costs. Furthermore, in answer to Mr. Pike's question. "Let's talk about the pay of the administrators of non-proprietary hospitals: What is reasonable there? Who says?", you did not mention what administrators receive, in pay, or prerequisites (autos, charters, compensation, etc.). What are the ranges of salary per patient bed? Clarification of these questions would be very helpful.

Regarding your statement that hospital employees in Baltimore, and in Maryland in general, earn amounts comparable to, if not higher than, similarly trained and employed people working outside the hospital, you said that you had significant data. Please send me this data as it will be helpful in an analytical report that is being written.

On a few other points, further data would also be helpful:

1. Which hospitals—you mentioned (p. 35) that there are five or six—have had major layoffs since the Commission started regulating their costs?
2. Which hospitals have the serious excess capacity problems? How would you qualify "excess capacity" exactly?
3. What are the occupancy levels of obstetrics and pediatrics in Maryland hospitals?
4. You stated (p. 40) that of the three hospitals in Maryland that have gone out of the obstetrics business in the past year, all have more gynecological business than before. Could you send me the details of the increase in this department?

One of the last things you mentioned during the hearing was that, although the Maryland Commission has authority to do rate review of all nursing homes in the State, it is not exercising that authority because Medicaid and Medicare do not pay your rates. Could you explain further?

Finally, before closing the hearing on May 14, I suggested the development of a "model program" for prospective reimbursement. I requested that the panel give us "at least the things that you think would be the elements in a model program so the Health Subcommittee can move forward on the matter." As of this moment, I have received no guidelines for a model program that could aid the Subcommittee in making progress on this question. Because the Health Subcommittee is meeting on August 3 to discuss this subject, I would appreciate a prompt response to this request.

I am returning to you for your files the testimony that you corrected.

Thank you for your continued cooperation on this matter.

Sincerely,

CHARLES A. VANIK,
Chairman, Subcommittee on Oversight.

STATE OF MARYLAND,
HEALTH SERVICES COST REVIEW COMMISSION,
Baltimore, Md., August 9, 1976.

Hon. CHARLES A. VANIK,
Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR CHAIRMAN VANIK: The following is an attempt to answer point by point the quetions you raised in your letter of July 7, 1976.

1. The reasons hospitals rates have been able to increase considerably less than hospitals costs is because under the Commission's system Blue Cross of Maryland pays a larger percent of hospital's charges. The increase in net revenues, however, have kept pace with the increase in cost.

2. I am including, as per your request, a copy of the brief submitted by the Commission to the Court of Appeals regarding the Maryland Hospital Association case. That Appeal did not refer to our guidelines because we had told the District Court that they were not regulations and the District Court filing that they were not properly adopted didn't disturb us since we didn't treat them as regulations anyway.

3. We have just signed a contract with the Social Security Administration and after the first round of rate review is completed early next year, we expect that Medicare will begin to pay Commission approved rates.

4. Enclosed is a computer run of the cost per equivalent inpatient day per the management function for each hospital in Maryland. I have also included a list of all the other cost functions for which we have similar rankings.

5. I do not know the salary of administrators. We just know the overall cost of administration for equivalent inpatient day.

6. I am also including some data relative to our conclusion that hospital salaries compare favorably to non-hospital salaries. This will follow as the person in charge is on vacation. Sorry.

7. Among those hospitals which have had major layoffs are the following: Sinai, Johns Hopkins, University of Maryland, Maryland General, Lutheran, and Bon Secours. All these hospitals are in Baltimore City.

8. I am enclosing a copy of our quarterly volume statistics report which shows the latest occupancy statistics in Maryland. You should especially note the occupancy rates in all the hospitals providing obstetrics and pediatric services and selected other hospitals in medical/surgical service. The definition of excess capacity is defined in the excerpt from the Commission staff's Guidelines entitled Target Occupancy and included with this letter.

9. The three hospitals in Maryland which have gone out of the obstetrics business are Bon Secours and Church Hospital of Baltimore and Suburban Hospital in Bethesda. While we do not have detailed case mix data, my report to you was based on statements from the administrators of those hospitals.

10. Your next question asked why we are not exercising our authority to review nursing homes because Medicare and Medicaid do not pay Commission approved rates. Together those federal programs cover almost 70% of all nursing home patients in the State of Maryland. The Commission believes it would be a waste of tax payers dollars to review patients and set rates which a majority of payers are not affected by in a situation where there are market protection in the way of many suppliers for those who do pay rates.

Finally, I am enclosing some thoughts toward a model program for rate setting. This outline was presented recently as testimony before Mr. Rostenkowski's Subcommittee on Health.

I want to thank you again very much for the opportunity you have given to me to present our thoughts and findings to your Subcommittee.

Yours truly,

HAROLD A. COHEN.

[Mr. Vanik also submitted the following:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., August 25, 1976.

Hon. CHARLES A. VANIK,
Chairman, Subcommittee on Oversight, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. VANIK: This is in reply to your letters to Commissioner Cardwell, Dr. Gaus, and myself. Thank you for sending us copies of your proposed draft report on the Subcommittee's two days of hearings concerning the experiments and demonstration projects authorized under the Social Security Amendments of 1972.

In general, we are in agreement with the recommendations on the structure of a prospective reimbursement system contained in the proposed draft report. We believe, though, that in addition to the recommendations listed in the report, two additional conditions are necessary. To be effective, a prospective reimbursement system should include all payers—Medicare, Medicaid, Blue Cross, commercial insurers, and self-insurers—so as to prevent inappropriate shifting of costs from one payer to another. This does not mean that some price adjustment cannot be applied to reflect the fact that hospital costs for Medicare patients may not be the same as hospital costs for other patients. We also recommend that to reduce the potential for subjective decision-making and to make the rate-determination process less costly, statistical measures need to be developed to set hospital reimbursement rates. A combination of tight statistical formulas and a reasonable exception process appear at this time to be necessary components of a workable prospective reimbursement system.

We share your concern that information resulting from HEW's research efforts on more efficient and less costly ways to deliver quality health care should be made available to the Subcommittee on Oversight as soon as possible. We will keep you informed of the results of our research efforts as such information becomes available.

Sincerely yours,

ELMER W. SMITH,
Associate Commissioner for Program Policy and Planning.

Mr. ROSTENKOWSKI. Dr. Finley and Dr. Reiss, welcome to the committee. Would you identify yourselves for the committee please.

STATEMENTS OF JOANNE F. FINLEY, M.D., COMMISSIONER, AND JOHN REISS, PH. D., ASSISTANT COMMISSIONER, NEW JERSEY DEPARTMENT OF HEALTH

Dr. FINLEY. I am Dr. Joanne Finley, State Health Commissioner of New Jersey, and Dr. Reiss is Assistant Commissioner for Health Planning and Resources Development which includes New Jersey's health facilities ratesetting program.

Mr. ROSTENKOWSKI. Your entire statement will be included in the record, Doctor, and you may proceed.

Dr. FINLEY. To give a very brief background, in 1971 the New Jersey Legislature was one of the first six in the country to pass a health care facilities planning act, which combined planning and ratesetting in a single State agency, the New Jersey Department of Health. Mandated, with consultation with the insurance commissioner, the State health commissioner set Blue Cross health rates, and the health commissioner has sole responsibility for rates by which various government agencies pay for health care services provided by health care facilities, and that is all facilities, not just the hospitals.

When I was appointed Commissioner of Health in New Jersey in 1974 I found that the previous administration had delegated this function to the Hospital Research and Education Trust of the New Jersey Hospital Association. I would have to say that the obvious results of this system were very little health care cost control largely because of a disorganized system and a tendency to do a great deal of retrospective adjustment of hospital budgets.

It was the decision of Gov. Brandon Byrne that the full statutory authority of the two departments would be exercised.

The methodology we have employed is covered fully in my written testimony thus, I will now go to the kinds of questions you have asked us to address, except to say that we are now in midstream in a system which is not fully prospective although we are pushing toward that as rapidly as we can.

Our basic philosophy is to hold hospitals accountable for those costs which they can control, to encourage them to institute effective management controls over their activities, and to generate reviews of their ongoing programs which appear to be excessively costly.

However, there are certain expenditures which we do not at this time subject to the screening process because we do not consider them controllable by the hospital. These include medical malpractice insurance premiums, utility expenses, although we are going to change that to a degree, depreciation, interest, and unanticipated variances in volume or in general inflation in the economy.

Now as to the issues that you have asked witnesses to address, I would like to go through what in our 2 years of experience we have seen and give you some examples of what we find contributes to the rapid rise in the cost of hospital care.

Certainly, first, is the main subject which you are addressing, and that is that retrospective reimbursement systems do not encourage good management by hospitals. There is the human tendency for such a system to end up reimbursing all expenditures each institution has made no matter the original goals.

Our experience would certainly support that argument, and just to give a couple of examples, in 1974 4 hospitals—and this is 4 of 118—4 hospitals alone in the State spent $2.25 million more than was approved in their original budgets even though their patient-days decreased more than 1 percent. That was the year when HRET was still reviewing their budgets and, therefore, they allowed retrospective adjustments to cover the $2.25 million over expenditures.

I guess I don't need to belabor another reason for high costs in hospitals, and that is the fact that the usual real market constraints do not exist. People have very little choice of product; that is, which hospitals they will go to.

Governmental payment systems and insurance payment systems which put a distance between the consumer, his pocketbook, and the responsibility for paying the bill—this has made the average consumer much less conscious than he should be of the escalating costs.

I will just give a couple of examples of what one does with a ratesetting system to try to encourage a more normal market situation. For example, in our 1975 and 1976 New Jersey reimbursement systems we have encouraged—in fact, virtually mandated—joint purchasing by certain hospitals. We have done this by challenging various cost centers as excessive and refusing to reimburse the total request. This activity alone has led to a decrease in supply costs of 2 percent for 1 year.

Group purchasing has generally saved $1.1 million in 1975 and we believe it will save $2.1 million in 1976.

Also hospitals in the past were able to maintain certain departments experiencing very low utilization. A classic example today is the labor and delivery room. Following changes in New Jersey to proposed budgets in 1976, a hospital decided to close its obstetrical services. Other hospitals in the surrounding area were experiencing significant underutilization of the same service and they will be able to pick up the patient easily who needs the care.

So an effective ratesetting system can begin to encourage the results one would expect if an effective market mechanism existed.

A third reason we see for the high cost of hospital care, and this is one I feel is being stressed here, but I would like to stress it especially—this is the effects of sophisticated technology.

The unlimited introduction of sophisticated technology to diagnose or treat illness which has sometimes been encouraged and funded by Federal research programs, we find to be another key reason for increasing costs.

The introduction of the computerized axial tomography scanner is a good example. Perhaps more interesting technological change lead to the introduction of new prices of equipment, the prices of which vary tremendously. It is alleged the practice of medicine in different instances requires different equipment. But what we see in the data submitted to us in the budget review and ratesetting system variations in the price of the same Coulter Counter Model S from $30,000 to $90,000 per unit. This seems to require some explanation.

Other variations of price include auto analyzers from $75,000 to $173,000, linear accelerators from $140,000 to $311,000, and ultrasound scanners from $25,000 to $79,000.

Another reason for high costs is seen in the increasing use of resources, and there are times when we feel this is related to the kind of technology explosion we seem to be experiencing in this country. We found that there is a marked tendency in hospitals to steadily increase the amount of resources per patient-day. For example, in New Jersey since 1973 the nursing hours per patient-day in acute care units have risen from 5.3 to 5.6. Since more than 7.5 million patient-days are budgeted for 1976 you can see that just that little decimal of hourly increase does have a tremendous effect on costs.

Similarly, in intensive care units the increase in patient-hours per day is from 14.2 to 15.5, with over 4,000 patient-days budgeted for intensive care. Because of this increase, the total wage bill has been rising. However, our experience indicates at least 50 percent of the cost increase is due to the increase in the use of technology and associated supplies and personnel. Increases in the unit cost of labor, especially for the low-income workers is not the major factor to us in explaining hospital cost increases.

The effects of malpractice insurance have been mentioned many times today and I will only add New Jersey's example. The hospitals in New Jersey at this point project a cost in their professional liability insurance that will probably add about $30 per patient statewide to the bill.

Mr. Cotter. Per day?

Dr. Finley. For total stay.

Now, the subject of uncontrolled addtions to capital.

Prior to 1971 in New Jersey additions to the capital plants of hospitals were uncontrolled. The long-run effects of this are now beginning to show. For example, new construction at two hospitals very close to each other was grandfathered after the passage of the 1971 New Jersey Health Care Facilities Planning Act, which did include a required certificate-of-need process. The capital cost of one of these grandfathered hospitals was $7 million and the other was $19 million, and that was some time ago.

Presently one of these hospitals has an occupancy rate of 54 percent of capacity and the other has 76 percent. It is clear institutions running with such utilization rates have much higher costs than necessary. If the existence of excess capacity leads to unnecessary admissions, as is alleged, and I believe it does, then the cost of adding this new capacity is really even higher.

I will speak a bit about the results of the New Jersey hospital rate legislation. Remember, we began in the middle of the year 1974 with the complete support of the Governor, so that during the year 1975 the Department of Health was deeply involved in instituting a new system for hosptial budget review and ratesetting, with all of the problems implied in the transition from the private or voluntary system to the public sector. Yet in that first year of our activities we succeeded in eliminating $58 million in unnecessary and unjustified expenses for Blue Cross and medicaid alone.

As indicated earlier, our activity has also had some effect on management practices in some hospitals. The rate of increase in New Jersey hospital costs in 1975 was held to about 12.5 percent compared to over 16-percent nationally. During 1976 hospitals in their proposed budgets have requested a 22-percent increase over their 1975 approved budgets.

At the present time the State's rate review system is holding the increase to approximately 6.5 percent. Of course, the 6.5 percent is not final. There is still the due process of appeals to go through.

The 1976 system is more prospective than that used in 1975. There are far fewer automatic retrospective adjustments, therefore the potential variation after the prospective rates are finally established is, I believe, much smaller.

You have asked us to give our opinion on the role of State regulation in the medicare reimbursement hospital system. It is my strong opinion that States which have developed or are developing effective cost containment systems should be delegated the responsibility of establishing the medicare hospital reimbursement rates. It is not practical to have a Federal system for medicare reimbursement which is different from that which States use for other payers.

It is crucially important that a prospective system cover all payers, including medicare. Otherwise, the hospitals actually boast that they still have other payors to whom they can shift the overrun expenditures.

We find, too, that reimbursement regulation is a very important tool for implementing the objectives of an appropriate health plan, but it cannot be an effective tool if hospitals can always pay for unnecessary activities by imposing the cost on payors whose rates are not controlled.

Cost shifting does take place. This is clear from our experience in New Jersey. For example, to pick just one hospital, charges have been raised but the hospital has not lost patients. This hospital has changed from a net revenue of minus $149,000 to one of $232,000-plus between 1974 and 1975.

Patient service revenues in that institution rose over 22 percent. Since the reimbursement from Blue Cross and medicaid, which we control, did not increase at the rate at which revenues increased, it is clear that the increase is being paid largely, I presume, by commercial insurance companies and medicare.

It seems to me very important that medicare maintain considerable flexibility in the manner in which it reimburses hospitals over the next few years until the state of the art of cost containment is improved.

The SSA, as we know, is able to fund a series of demonstration projects to test the different methods of reimbursement to see their relative effectiveness. New Jersey has a proposal before them to develop a system which takes account of the patient case mix of various hospitals. We feel that this type of methodology will permit a more accurate type of identification of the resources needed by hospitals and will clarify the necessary differences in the delivery of care to patients between hospitals.

I think it will sort out the unnecessary differences, too. Such a system would permit the identification of types of patients covered by different payers, and enable the hospitals' budgets to be met by third-party payers but for the patients for whom those payers are actually responsible.

We feel the element of cost covered by each payer must be consistent so the hospital is reimbursed for all of its legitimate expenditures. To us this does not mean that payments made by all payers should be identical.

For example, there may be good reason why some payers who have open enrollment provisions or other advantages for consumers should be given a somewhat different reimbursement rate. If you do a case mix analysis of costs and base hospital budgets on that, you may very well find that some payers have the simpler kinds of cases for which they are responsible.

You asked in the outline for these hearings how witnesses felt about alternative approaches to setting prospective rates. I certainly don't propose to discuss all the different systems that may exist, but if we are going to move as we should toward a pure prospective system, we would suggest a few things.

There must be some provision for a contingency fund allowed in a hospital's budget for totally unpredictable and uncontrollable costs.

Congressional attention to the root problems of uncontrollable health care costs will also help create a system in which there are fewer costly surprises. A national system for dealing with the malpractice issue and definitive attention to the energy needs and costs in the Nation are two examples of help still needed.

As I said earlier, we do feel that reimbursement based on the identification of patient case mix rather than continued use of a per diem rate will encourage a reduced length of stay. We will identify the real resources that the hospital has to use for its patient mix. We can clarify and compare the services actually provided by hospitals serving the same kinds of patients.

There is considerable discussion at the present time concerning the need for a system of a uniform chart of accounts for all hospitals and some of your witnesses have addressed this. It is our opinion, in New Jersey where we have a uniform reporting and a uniform cost allocation system, that a uniform chart of accounts is unnecessary and not even effective.

A system of uniform accounts would have up to 4 times as many cost centers as does the New Jersey uniform reporting sysem, which now uses 36 cost centers. This requires far more work for hospitals. It will have cost centers not needed for certain sizes or types of hospitals, and for reasons like this we find that a requirement for uniform accounting increases the costs which do get passed on to consumers. We also would tend to agree that it might increase the cost of the State bureaucracy because of the additional unnecessary work in analyzing extra data.

Finally, it is important that financial incentives, which can be positive or negative, be tied to health planning decisions and the certificate-of-need process. The systems must complement each other and I am proud to represent, I think, the only State that has testified so far in which planning, resources development and ratesetting are in the single State agency. It is very important to keep them together and knit them together.

You asked about choices. We agree with previous witnesses who do not feel that several methodologies should be offered for any permanent system you might recommend for medicare. It sounds a little cynical, but I have to state the only reason we could see for a hospital to choose one system rather than another, is because it feels it would be subject to less control.

Now a little bit more about the relation of Public Law 93–641, the Health Planning and Resource Development Act of 1974. In order to assure that plans are implemented, the reimbursement system must be one of the tools used and it can be a very effective tool.

Some examples of the way in which reimbursement may enhance the planning process follow: If the regional plans prove new services to be needed, they will only be reimbursed if they are undertaken in conformance with a properly issued certificate of need. Note I am talking of approval of expanded services, not just facilities.

The certificate-of-need review should insure that necessary services for the community are made available at the least cost and in the most effective manner. In New Jersey the health economic unit in the Division of Planning and Resource Development does also do the economic impact studies that go to the certificate-of-need processors.

Should a hospital institute a new service without receiving a certificate of need or institute a service which differs from the certificate of need, there should be no reimbursement.

Similarly the review of health services required by section 1513(b)(1) of Public Law 93–641 should be reinforced by the reimbursement system. In other words, if the Health Systems Agency recommends to the designated State health planning and development agency that a service is inappropriate reimbursement for that service should cease.

Perhaps Public Law 93–641 should be amended or regulations adopted to make this an explicit requirement of the planning process. As part of that process, the designated State agency and the Health Systems Agency should cooperate in finding appropriate social uses for any plant which would otherwise be rendered idle by this action.

Another valuable connection between health planning and the reimbursement system is for the latter to identify a reasonable portion of statewide consumer expenditures that should go for hospital expansion in a given year, and state this as an allowable cost increase due to capital expenses beforehand. The planners would then be required to work with that limit in their review of certificates of need and the service priorities established.

Finally, in order to provide greater incentives for the regionalization of specialized services, especially expensive tertiary care, reimbursement for such services should be limited to the identified regional centers.

We do feel, for a viable reimbursement system, all payors should be covered from the start. We have legislation to amend our 1971 act before our State Legislature, now hoping to extend the authority to cover rates set for all payors. I have already stressed the cost-shifting that can occur if this does not happen.

One area that I have not heard mentioned today that I would like to bring up is a subject that has been most difficult for our society to handle, but we feel it is essential to find a way to deal with it. That is those activities of providers who are allegedly engaged in the "private practice of medicine," but which activities have a significant effect on other health providers and increase cost burdens to payors.

Generally, such activities are relatively large in scale and cause changes in the sets of relationships developed among providers who offer various levels of care. For example, if a hospital has an underutilized radiology department, it does not make much sense to allow a private clinic to be built across the street where radiologists can treat patients as "private practitioners." This often leaves the hospital with even greater excess capacity, but also with the sole responsibility for providing services to patients who cannot afford to pay the cost, or whose reimbursement rates are controlled.

The duplication of effort and especially of equipment in this kind of situation is exceedingly costly to the consumers and the payors for health care.

We also will be sending in later a position paper on the Talmadge and Duncan bills. I would say very briefly that there is a good deal conceptually that we favor. There are also significant problems that we see. For example, we see a problem with covering only limited parts of total operating costs. We find that creative accounting can do wonders for a hospital even if a uniform hospital accounting system is adopted.

We think there are some deficiencies in the Talmadge and Duncan bills that would have to be corrected for cost increases really to be contained.

The last question you asked be addressed is that issue of the usefulness of establishing a medicare cap of ceiling. Court decisions in New Jersey in the past year have found the use of an administrative cap by medicaid unlawful because the methodology for deriving the cap is not presumptively reasonable. Under statutes such as New Jersey's which do require reimbursements at reasonable rates, there is no way a cap can be considered reasonable since it is arbitrary, if not even capricious.

I would suggest you allow States which have effective demonstration programs that have shown real cost containment without diminishing needed care to include medicare reimbursement as part of that program.

I should like to thank you very much, Chairman Rostenkowski, for the opportunity to present this question.

[The prepared statement follows:]

STATEMENT OF JOANNE E. FINLEY, M.D., M.P.H., COMMISSIONER OF HEALTH, STATE OF NEW JERSEY

In 1971, the New Jersey Legislature passed the Health Care Facilities Planning Act which gave the Departments of Health and Insurance authority to set the reimbursement rates, based on reasonable costs, for Blue Cross. The Commissioner of Health was mandated also to set the rates by which various government agencies pay for health care services provided by health care facilities. When I was appointed Comissioner of Health in New Jersey in 1974, I found this function for Blue Cross being undertaken by the Hospital Research and Education Trust of the New Jersey Hospital Association. Their approach was to review budgets at the beginning of the hospitals' fiscal year but to make substantial retrospective adjustments after the year was over. Because of the rapid escalation in hospital costs which was being reflected in large increase in Blue Cross premiums, the Administration of Governor Byrne decided that the Departments of Health and Insurance should assume full responsibility for implementing the Rate Review Program.

The Department of Health, with knowledgeable consultants, first developed a system for uniform financial reporting by all New Jersey hospitals. These forms were used first for reporting proposed budgets by cost centers in 1976. We have found this system has generated the first consistent and comparable data set for New Jersey hospitals.

A brief review of our methodology might be helpful to you. We have established some 36 cost centers for the hospitals. We have established some 36 cost centers for the hospitals. We compared these costs among like groups of hospitals, divided into categories such as teaching, urban, by size, etc. Before comparisons are made, costs are equalized to account for differences in regional labor markets within the State. By using a series of screens, hospitals in peer groups are compared for their base period costs. Those costs exceeding the screens are deemed presumptively unreasonable. Once the reasonable base period costs are established, an economic factor to account for price inflation over the next year is applied to those costs. In addition, if the hospital anticipates that the number of admissions will rise, an adjustment to the proposed hospital expenditures is permitted to account for that increase. A proposed administrative rate then is established, the hospital notified and sent a series of reports explaining the reasons why certain costs were challenged. The hospital then prepares its case to explain why it needs the provisionally disallowed expenditures. This case must be presented in terms of explaining the total program in those areas where costs are too high. They present this case to staff analysts of the Department of Health, and negotiations ensue. Following those discussions, the administrative payment rate is established and the hospital then has a right of appeal to a hearing officer. The final administrative rate is issued subsequent to the hearing officer's report.

Presently, there are certain expenditures which are not subject to the screening process because they are not considered controllable by the hospital. These include medical malpractice insurance premiums, utility expenses, depreciation, interest and unanticipated variances in volume or inflation. The basic philosophy of the system is to hold hospitals accountable for those costs which they can control, to encourage them to institute effective management controls over their activities and to generate reviews of their on-going programs which appear to be excessively costly.

I would now like to turn to the issues you have asked witnesses to address.

1. FACTORS CONTRIBUTING TO THE RISE IN THE COST OF HOSPITAL CARE

a. Retrospective Reimbursement Does Not Encourage Good Management

It is often proposed that retrospective reimbursement systems do not encourage good management by hospitals. There is human tendency for such a system to end up reimbursing all the expenditures each institution has made, no matter the original goals. Our experience would support that argument. For example, in 1974 four (4) hospitals in the State spent $2.25 million more than was approved even though their patient days decreased more than one percent (1 percent). The budgets allowed that year already included factors for general inflation. In a retrospective system which reimbursed actual costs, that cost overrun would be reimbursed and management would be under no incentive to improve its performance. When we initiated a partial prospective system, even allowing for some "pass-throughs", hospital managers were under incentives to reduce such cost overruns in the future.

b. Lack of a Competitive Market

There are no real market constraints operating on hospitals in that their services are used by people who generally have little choice of "product"—that is, of which hospitals they will use. Further, the consumer more often than not bears no direct responsibility for paying the bill. Thus hospitals can pass costs on to the consumer with relative ease. However, between 1975 and 1976 the New Jersey reimbursement system has encouraged joint purchasing by certain hospitals. We have done this by challenging various supply cost centers as excessive and refusing to reimburse the total request. This activity alone led to a decrease in supply costs of two percent (2 percent) in one year for some hospitals. Group purchasing in the State generally has saved payors about $1.1 million in 1975 and should save $2.1 million in 1976.

Hospitals in the past were able to maintain certain departments experiencing very low utilization, for example in labor and delivery rooms. Following challenges to their proposed budget in 1976, one hospital decided to close that department. Other hospitals in the surrounding area also were experiencing significant underutilization of obstetrical services and will pick up the people who need the care. Thus an effective rate setting system begins to encourage the results one would expect if an effective market mechanism existed.

c. Effects of Sophisticated Technology

The unlimited introduction of sophisticated technology to diagnose or treat illness, sometimes encouraged and funded by Federal research programs, we find to be another reason for increasing costs. The introduction of the Computerized Axial Tomography Scanner at an annual operating cost of $500,000 is a good example. Perhaps more interesting is that technologic change leads to the introduction of new pieces of equipment, the prices of which vary tremendously. It is alleged that the practice of medicine in different instances requires different equipment, but variations in the price of the Coulter Counter Model S from $30,000 to $90,000 per unit seems to require more explanation. Other examples of price variations include auto analyzers from $75,000 to $173,000, linear accelerators from $140,000 to $311,000 and ultra sound scanners from $25,000 to $79,000.

d. Increasing Use of Resources

We have found there is a marked tendency in hospitals to steadily increase the amount of resources per patient day. For example, since 1973, nursing hours per patient day in acute care units have risen from 5.3 to 5.6. Since more than 7½ million patient days are budgeted for 1976, you can see that that has a significant effect on costs. Similarly in intensive care units, the increase in hours per patient day is from 14.2 to 15.49, with over 400,000 patient days budgeted for intensive care.

Because of this increase, the total wage bill has been rising. However, our experience indicates that at least 50 percent of the increase in hospital costs is due to the increase in the use of technology and associated supplies. Increases in the unit cost of labor, especially for low-income workers, is not the major factor in explaining hospital cost increases.

e. Effects of Malpractice Insurance

A major increase recently for New Jersey hospitals is that due to medical malpractice insurance. After eight (8) months experience in 1975, hospitals were projecting that medical malpractice insurance costs would be just over $8 million for that year. They budgeted over $17 million for 1976, an increase of more than 110 percent. Now hospitals are indicating a need for still larger increased in liability insurance. It appears likely that it will cost those who pay for hospital care in New Jersey between $30 million and $35 million for 1976. This is an expense of better than $30 per patient statewide.

f. Uncontrolled Additions to Capital

Prior to 1971, additions to the capital plant of hospitals was uncontrolled. The long-run effects of this are now beginning to show. For example, new construction at two hospitals very close to each other was grandfathered after the passage of the 1971 Act, which included a required Certificate of Need process. The capital cost of one was $7 million and of the other was $19 million. Presently, one of these hospitals has an occupancy rate of 54 percent of capacity and the other, of 76 percent. It is clear that institutions running with such low utilization rates have much higher costs than are necessary. If the existence of excess capacity leads to unnecessary admissions as is alleged, then the cost of adding this new capacity is really even higher.

2. RESULTS OF NEW JERSEY HOSPITAL RATE REGULATION

During 1975 the Department of Health was deeply involved in instituting a new system for hospital budget review and rate setting, with all the problems implied in transition. Yet, we succeeded in eliminating $58 million in unnecessary and unjustified expenses during that year for Blue Cross and Medicaid alone. As indicated earlier, our activity has also had some effect on management practices in some hospitals. The rate of increase in New Jersey hospital costs in 1975 was held to about 12½ percent compared to over 16 percent nationally.

During 1976 hospitals in their proposed budgets, requested a 22 percent increase over their 1975 approved budgets. At the present time the rate review system is holding the increase to approximately 6½ percent. Of course, the 6½ percent figure is not final. The 1976 system is more prospective than that used in 1975 in that there are far fewer automatic retrospective adjustments. Therefore the potential variation after the prospective rates finally are established is much smaller. As an example of the effectiveness of a "pure" prospective system, a sample of 30 hospitals actually spent $3 million more in 1975 than had been approved. In a "pure" system ,there would be no adjustment for that $3 million. The hospitals would have had to decide on a new allocation of their expenditures during the year if those rising costs had to be incurred and were outside their control.

3. THE ROLE OF THE STATE REGULATIONS IN THE MEDICARE HOSPITAL REIMBURSEMENT SYSTEM

It is my strong opinion that States which have developed or are developing effective cost containment systems should be delegated the responsibility of establishing the Medicare hospital reimbursement rates. It also is not practical to have a Federal system for Medicare reimbursement that is different from that which States use for other payors. It is crucially important that a prospective system cover all payors including Medicare. Otherwise the hospitals actually boast that they still have other payors to whom they can shift overrun expenditures. Reimbursement regulation is also an important tool for implementing the objectives of appropriate health plans, but it cannot be an effective tool if hospitals can always pay for unnecessary activities by imposing the cost on payors whose costs are not controlled. Cost shifting does take place. This is clear from the experience in New Jersey. For example, one hospital has raised its charges and not lost patients. This hospital has changed from a net revenue of minus $149,000 to one of plus $232,000 between 1974 and 1975. Patient service revenues in that institution rose over 22%. Since the reimbursement from Blue Cross and Medicaid did not increase at the rate at which revenues increased, it is clear that the increase is being paid largely by commercial insurance companies and Medicare.

It seems to me very important that Medicare maintain considerable flexibility in the manner in which it reimburses hospitals over the next few years until the "state of the art" of cost containment is improved. The Social Security Administration is able to fund a series of demonstration projects to test different methods of reimbursement to see their relative effectiveness in containing costs. New Jersey is proposing to develop a system which takes account of the patient case mix of various hospitals. We feel that this type of methodology will permit a more accurate identification of the resources needed by hospitals and will clarify necessary differences in the delivery of care to patients between hospitals. Such a system would permit an identification of the types of patients covered by different payors and enable the hospitals' budgets to be met by third party payors according to the kinds of patients the hospital was treating for that payor. We feel that the elements of costs covered by each payor must be consistent so that the hospital is reimbursed for all its expenditures. But that does not mean that the payments made by all payors should be identical. For example there may be good reason why some payors who have open enrollment provisions or other advantages for consumers should be given a somewhat different reimbursement payment than payors not providing such benefits.

4. ALTERNATIVE APPROACHES TO SETTING PROSPECTIVE RATES

I do not plan to discuss all the different systems which may exist for reimbursing hospitals, but there are certain issues that are very important. If we are going to move toward a "pure" prospective system then there must be some contingency fund for totally unpredictable and uncontrollable changes in costs. Congressional attention to the root problems of uncontrollable health care costs will also help create a system in which there are fewer costly surprises. A national system for dealing with the malpractice issue, and definitive attention to the energy needs and costs in the nation are two examples of help still needed.

We feel that reimbursement based on the identification of the patient case mix in a hospital rather than the continued use of a per diem rate, will encourage reductions in the length of stay. We will identify the real resources that the hospital has to use for its patient mix. We can clarify and compare the services actually provided by hospitals serving the same kinds of patients. This is a method for defining payors' responsibilities on a more equitable basis. We believe case mix reimbursement will enhance the possibility for documentation of the quality of care provided and of the appropriateness of the utilization of the hospital. We intend to build both of these elements into performance or productivity screens in the future New Jersey system.

There is considerable discussion at the present time concerning the need for a system of uniform charts of accounts for all hospitals. It is our opinion that this is unnecessary as an effective system for uniform reporting and uniform cost allocation, such as exists in New Jersey at present, is sufficient. A system of uniform accounts will have up to four (4) times as many cost centers as does the New Jersey Uniform Reporting System, hence requires far more work for hospitals. Also, it will have cost centers not needed for certain sizes or types of hospitals. For these reasons, we find that a requirement for uniform accounting increases the cost of running hospitals. In addition it will increase the cost of the State bureaucracy because of the additional unnecessary work in analyzing extra data.

Finally it is important that financial incentives, which can be positive or negative, be tied to health planning decisions and the Certificate of Need process. The systems must complement each other.

5. CHOICES

It is not feasible to offer hospitals a choice of several methodologies for a permanent system. The only reason for a hospital to choose one system rather than another is because it would be subject to less cost control. A State system, within performance criteria specified by the Federal government, allows a more flexible approach to be taken where regional problems of health service delivery differ. The integration of reimbursement and health planning is more likely at a State level than at the Federal.

6. RELATION TO P.L. 93641 THE HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974

In order to ensure that plans are implemented, the reimbursement mechanism must be one of the tools used. Some examples of the ways in which reimbursement may enhance the planning process follow. If the regional plans prove new services to be needed, they will only be reimbursed if they are undertaken in conformance with a properly issued Certificate of Need. The Certificate of Need review should ensure that the necessary services for the community are made available at the least cost and in the most effective manner. Should a hospital institute a new service without receiving a Certificate of Need or institute a service which differs from the terms of the Certificate of Need, there should be no reimbursement. Similarly, the review of institutional health services required by Section 1513 (G)(1) of P.L. 93–641 should be reinforced by the reimbursement system. In other words, if the Health Systems Agency recommends to the designated State Health Planning and Development Agency that a service is inappropriate, reimbursement for that service should cease. Perhaps P.L. 93–641 should be amended, or regulations adopted, to make this an explicit requirement of the planning process. As part of that process, the designated State Health Planning Agency and the Health Systems Agency should cooperate in finding appropriate social uses for any plant which would otherwise be rendered idle by this action.

Another valuable connection between health planning and the reimbursement system is for the latter to identify a reasonable portion of consumer expenditures that should go for hospital expansion in a given year, and to state this as allowable cost increases for hospitals due to capital expenses. The planners would then be required to work with that limit in their review of Certificates of Need and the service priorities established within the plan to allocate resources among the necessary needed services up to the dollar sums allowed. Finally, in order to provide greater incentives for the regionalization of specialized services, especially for expansive tertiary care, reimbursement for such services should be limited to the identified regional centers.

7. PHASING IN THE SYSTEM

It is extremely important that for a viable reimbursement system that all payors be covered from the start. As I indicated earlier, the New Jersey experience with a system covering some payors but not all is that institutions are able to avoid the effects of the budget and rate review program and hence, fail to improve their management practices or refine their review of the need for the services they offer. It does make sense to start with the hospital industry as that covers the major proportion of medical care expenditures and a most significant proportion of the cost of the entire health delivery system. Other institutional providers should be added in later phases but it is important that we know what we are doing in one phase before we move on to the next.

One area above all has been the most difficult for our society to handle, but we feel it is essential to find a way to deal with it. That is, those activities of providers who are allegedly engaged in the "private practice of medicine" but which have a significant effect on other health providers and in increasing cost burdens to payors. Generally, such activities are relatively large in scale and cause changes in the sets of relationships developed among providers who offer various levels and intensities of care. For example, if a hospital has an underutilized radiology department, it does not make much sense in terms of resource allocation to have a private clinic built across the street from the hospital where radiologists can treat or diagnose patients as private practitioners. This leaves the hospital with even greater excess capacity but also with the sole responsibility for providing services to patients who cannot afford to pay the cost, or whose reimbursement rates are not controlled. The duplication of effort and especially of expensive equipment in this kind of situation is exceedingly costly to the consumers of and payors for health care.

8. COMMENTS ON THE TALMADGE AND DUNCAN BILLS

Attached to this testimony is a copy of the position paper developed by the State of New Jersey on the Talmadge and Duncan Bills. This will be submitted for the record at a later date. I do want to draw your attention to the fact that we see some real problems for the reimbursement of hospitals under Medicare in the methodology outlined by those bills. There are significant problems with covering limited parts of total operating costs. Creative accounting can do wonders for a hospital even if a uniform accounting system is adopted. The possibility of containing cost increases will be very slight. In our rate setting program in 1975 we did divide labor costs and supply costs and found that it significantly limits the management decision of hospitals and creates problems for the reimbursement process. There are obviously many trade-offs between labor, capital and supplies which effective management should consider. Therefore in our view it is much better to give the hospitals an overall increase in their allowed budget for inflation and volume effects and to leave it to the hospital to decide how to allocate these expenditures among the possible alternatives.

9. USEFULNESS OF A MEDICARE CAP OF CEILING

Court decisions in New Jersey in the past year have found the use of an administrative cap by Medicaid unlawful because the methodology for deriving the cap is not presumptively reasonable. Under statutes such as New Jersey's which require reimbursement at reasonable rates, there is no way that a cap can be considered reasonable since it is clearly arbitrary, if not even capricious! I would suggest that you allow states which have effective reimbursement programs that have demonstrated real cost containment without diminishing needed care to include Medicare reimbursement as part of that program.

I should like to thank the Committee for the opportunity to present this testimony and will be happy to respond to any questions you may have.

TESTIMONY OF HON. BRENDAN BYRNE, GOVERNOR, STATE OF NEW JERSEY, BEFORE THE SENATE FINANCE COMMITTEE, SUBCOMMITTEE ON HEALTH

Mr. Chairman, I am pleased to submit for the Committee's record New Jersey's position regarding Senate bill 3205, the Medicare-Medicaid Administrative and Reimbursement Rate.

As Governor of the State of New Jersey, I have taken an active interest in the containment of health care costs not only through administration of the State's Medicaid program but also through implementation of a state hospital reimbursement program for Blue Cross and other government payors. However, despite our conscientious efforts, the problem is larger than any one state's ability to control. Since the federal government is the single largest purchaser of health care in this nation, we must look to this sector if we are to have any major success in our battle to control health care costs. These proposed amendments to the Social Security Act are, for the most part, proper steps toward this goal.

Recognizing the importance of this legislation and the complex technicalities inherent in these amendments, I asked staff of both the Medicaid program and the hospital reimbursement program to submit comments of which the following are a distillation.

The proposed bill contains three major sections of concern to New Jersey:

Program Controls & Administration;
Hospital Reimbursement Reforms;
Physician Reimbursement Reforms.

PROGRAM CONTROLS

New Jersey favors the concept of reorganization within DHEW as detailed in Section 2 and 3 of this bill. This reorganization—including establishment of a health care financing administration and an Office of Central Fraud and Abuse Control—should accomplish improved fiscal control over the Medicare and Medicaid programs. We do believe that a centralized fraud and abuse operation is a good concept if it lends itself to a coordinated effort with states. However, this office should not prevent intermediaries and carriers from continuing to investigate suspected program abuses. It is important, as well, that this office be subject to a limited budget and staff in order not to develop a large organization in competition with the Department of Justice. We trust that the function of an Inspector General, whose title should be changed to something less militaristic, and the office he manages, will be supportive of not parallel to the role of this primary law enforcement agency.

We are concerned, however, that the Inspector General should exert a coordinative influence on states, which must also relate to HEW regional staff and HEW auditors in addition to many other local reviewers, or they may well be in a state of continuous audit or investigation.

Not only are administrative controls necessary at the federal level, we agree that better controls are also needed at the state level in order to ensure program integrity.

However, as Section 4 is presently drafted, there are several deficiencies from New Jersey's perspective. First, in the area of program eligibility, the bill requires that this determination be made within thirty days for all categories of eligibility with the exception of disability. This section must exclude federally determined eligibility processes from the limited time periods now specified. Second, in the area of quality controls, we suggest consideration of a range for normal error rates, rather than the 50th percentile of base year error rates for all states. Some states would have to exceed the 50th percentile as proposed in the bill; compliance with error rate requirements should be phased in over a reasonable period.

HOSPITAL REIMBURSEMENT REFORMS

From New Jersey's experience implementing a rate setting process, Sections 10, 11 and 12 of this bill are centrally important to the proposed cost-containment effort in hospitals. These sections would add additional criteria for determining reasonable costs of hospital services under Medicare and Medicaid. Based upon our experience, however, several aspects of each of these sections require further consideration.

Section 10

First, this program does not attempt to encourage states to establish reimbursement mechanisms for all payors for patient care in hospitals as a required condition for payment of federal matching funds to the states for Medicaid programs. Accordingly, these amendments may reduce the increase in costs to the Medicare and Medicaid programs but they will not contain total hospital costs. Thus this program will shift the burden of payment from Medicaid and Medicare to other third party payors and fee-paying patients while failing to contain total hospital related expenditures.

While standardization of classification schemes makes interstate comparisons far easier, the proposed classification of hospitals is unnecessarily complex. Furthermore, allowing medical schools only one primary affiliate could cause New Jersey very real problems. Similarly, the proposed accounting classifications are undesirable, based upon our State's rate setting experience.

Basing the entire system on routine operating costs raises serious questions about the integrity of the system. Unless a very carefully developed set of uncontrovertible definitions is used with follow-up auditing, any system which covers only part of hospitals' expenses is likely to encourage "creative accounting" rather than cost-containment by hospital administrators. Furthermore, the division of these routine costs into personnel and nonpersonnel components is problematic as the New Jersey Department of Health discovered in 1975 rate reviews. Rather than requiring hospital management to decide the appropriate trade-offs between labor and capital, or wages and productivity, the State is required to confront the problem head-on.

Section 10 has additional problems. First, the role of the JCAH indicated in part D is most inappropriate, since it sustains the role of an industry-oriented body, subject to no public controls, as a quasi-public agency. Second, the lack of specificity is disturbing regarding price indices for reimbursement of personnel and waivers due to changes in the hospital's patient mix. With respect to price indices in particular, the rate of increase in personnel costs is determined from hospital industry data. This fact places no incentive on the hospitals to reduce costs, for if the average costs can be forced up, all hospitals will be reimbursed accordingly. Depending upon the distribution of hospital costs, most hospitals might benefit from employing such a strategy. In New Jersey, the state uses an "economy-wide" index.

Section 11

We applaud the bill's attempt to incorporate occupancy considerations with the rate setting process in Section 11. However, we believe that the Health Systems agencies and the State Health Planning and Development Agency created pursuant to PL 93–641 should be specified as having a relation to this system. There is no question that underused facilities should be closed where possible; however, this decision should be part of the planning process and reinforced by reimbursement programs. Although HSA's vary in scale and function across the nation, their required input in this process will assist in developing a common rule and will clearly support the intent of PL 93–641. Establishing a Board to do this evaluation on a National basis is unrealistic. A five-member board could not possibly handle the workload or appreciate complexities of local area problems.

Section 12

This provision would increase the allowable return on equity to be included in determining reasonable costs by proprietary hospitals. New Jersey does not feel this should be implemented because the current return on equity is quite adequate, providing an 11% to 12% return. However, if this section should be retained, the States should have the option, not the obligation of paying up to twice the average rate of interest. Clearly, money market conditions vary in different regions of the country.

PHYSICIAN REIMBURSEMENT REFORMS

We recommend that existing law be changed to provide for the updating of physician profiles and prevailing charges on a semiannual basis. The current system of annual updating on July 1 of each year based on charges rendered during the prior calendar year produces an excessive time lag. This is a disincentive for the physician to consider whether to accept assignment of benefits. We anticipate that the impact on beneficiaries will be significant and should be weighed in the cost-control calculus. If the proposed approach does, in fact, further limit annual increases in prevailing charges, with further decreases in the assignment rates, the elderly beneficiary will be even harder hit than he now is for out-of-pocket expenses. We recommend that this proposal be deferred until impact on beneficiaries can be quantified and evaluated. Alternative payments under Medicare should also be investigated to arrrive at the best possible solution from the beneficiary's perspective.

Further modifications should be made in Section 21 to stimulate physicians' acceptance of assignment. As the bill is presently drafted, incentives for acceptance of assignments by physicians under Medicare are not strong enough. We believe that physicians should be compelled to accept assignment as a condition of participation in the Medicare program. Until such a requirement is executed. Medicare beneficiaries will continue to experience soaring out-of-pocket medical expenses.

Furthermore, the concept of "participating" and "non-participating" physicians as defined in this bill will be counterproductive if implemented. The "all or nothing" approach to assignments may drive the assignment rate down because the "Incentives' 'in this section are not sufficient to achieve a high rate of participation. In fact, the billing and payment procedures may be a disincentive which will not be overcome by the $1.00 per patient "incentive."

Furthermore, we envision terribly difficult administrative problems under the proposed modified billing form if all other requirements under existing rules and regulations must be met. Also, the partial payment to the physician within five days followed later with the many individual adjustments with respect to the deductible, reasonable charges, utilization, and eligibility determinations will create more record keeping problems for the physician's office assistant. An alternative approach which would be to provide that reasonable charge determination for participating physicians be based on the 90th percentile rather than the 75th. To improve administrative procedures, it might be required that participating physicians code all claims.

As for physicians affiliated with hospitals, described in Section ZZ, we find that there is a need for further control. Some clarification is necessary to define the term "reasonable" and the limiting provisions for anethesiologists. We do not agree with the payment of benefits without coinsurance for participatory physicians. We also believe that this section should apply to all hospital-based physicians. Consideration should also be given to providing that reimbursement to all hospital associated physicians be made on the basis of reasonable cost to the hospital with payments under Part A of Medicare. All provisions of this section should apply to Medicaid as well.

Finally, Section 25 should improve the quality of care rendered under the Medicaid programs and should decrease utilization problems. There is the potential, however, that this provision might cause problems for states, such as New Jersey, which face difficult financial straits, if it did not concurrently bring a reduction in the use of costly facilities such as hospital rooms. Despite this drawback, New Jersey supports this provision to overcome present tendencies to prescribe higher treatment more frequently than necessary.

In conclusion, Mr. Chairman, may I reiterate that New Jersey supports the proposed legislation in large measure. We are pleased to have had this opportunity to contribute our comments for the record. We look forward to supplying whatever assistance you might need to develop amendments consistent with those noted in this statement.

Mr. Rostenkowski. Are there any questions of the witness?

Thank you very much.

Mr. Raino, welcome to the committee. Would you identify yourself?

STATEMENT OF DOMINIC B. RAINO, STAFF DIRECTOR, HEALTH FINANCING AND REIMBURSEMENT, HEALTH AND RETIREMENT FUNDS, UNITED MINE WORKERS OF AMERICA

Mr. Raino. My name is Dom Raino, staff director, Health Services Department, United Mine Workers of America, Health and Retirement Funds, located here in Washington.

The Health and Retirement Funds are grateful for this opportunity to appear before this subcommittee to present testimony on the issues involved in rising hospital costs and possible revisions in the present retrospective cost reimbursement system used in the medicare program.

Mr. Chairman, I have submitted a copy of my testimony to the committee staff. I will highlight my testimony but ask that the entire testimony be submitted for the record.

Mr. Cotter. Without objection it will be admitted.

Mr. Raino. The funds provide health and pension benefits to a population of over 760,000 coal miners, retired and disabled miners, and their dependents, living in 48 of the 50 States, but concentrated in the coalfield areas of Appalachia, the Upper Mississippi Valley, and the rural West. Of these three-quarters of a million people, about 118,000 are presently medicare enrollees, for whom the funds pay the medicare part A deductibles and coinsurance. We also pay for all part B services for these beneficiaries as a group-prepaid practice plan dealing directly with the Social Security Administration.

The funds are multiemployer joint trusts established under section 302 of the Taft-Hartley Act. The agreements under which we operate are adopted as part of the collectively bargained wage agreements between the United Mine Workers of America, the Bituminous Coal Operators Association, the Association of Bituminous Contractors, and individual coal miner operators and coal haulers.

Eligibility for and level of benefits, and rates of payment from the signatory companies are established for the term of the collective bargaining agreement by the trusts' settlors. The funds are administered by a three-member Board of Trustees. The present trustees are Harry Huge, chairman, appointed by the union, C. W. Davis, appointed by the employers, and Paul R. Dean, a jointly appointed neutral trustee. The three trustees are committed to act solely in the interests of the persons covered by the trusts and are bound by the fiduciary responsibility established in the Employee Retirement Income Security Act of 1974.

As you know, coal mining is one of the most dangerous occupations in the United States and it should, therefore, be no surprise that our population has a very high rate of medical problems which require professional care. The high incidence of disease and accidents, coupled with the traditionally poor access to medical care in the rural areas we serve, and compounded by other hardships of rural and mountain life, have made the 27 years of the funds' medical program a unique chapter in American health care. In 1975 the funds paid out almost $200 million for health care for our covered population, about $40 million of that for beneficiaries on medicare.

Our concern with rising health care costs and with the systems used to pay for health care services derive from our purposes as stated in the trust documents to:

(1) Provide beneficiaries of the trusts with quality health care;

(2) Improve the delivery of quality health care services;

(3) Assist beneficiaries in solving their health needs through education and prevention measures;

(4) Assist the beneficiaries, wherever practical, in improving their general health and living conditions.

These general goals are, however, constrained by the fixed level of income to the funds set by the wage agreement, and by the responsibilities of the trustees under ERISA to insure the availability to benefits into the future. In this regard we are in a position similar to the thousands of other jointly administered trusts established under Taft-Hartley and covered by ERISA.

While the funds do not provide medical care directly to our beneficiaries, we also do not operate strictly as a third-party payer. Rather, we see our role as both arranging, facilitating and paying for health care for our population, and as working with both providers of care and beneficiaries to control costs and improve the quality of care. The benefits we include are quite comprehensive. They include all physician care, both in and out of the hospital, hospital costs, and chronic care drugs.

The major exclusions are dental care and routine eye care and eyeglasses. For those beneficiaries covered by medicare currently about 118,000 persons, we provide coverage for most of the costs not reimbursed by medicare, including the deductibles and coinsurance. The burden of increased health care costs thus fall on the trusts, not on our beneficiaries directly.

In 1974 the funds made substantial payments to about 16,000 health care providers for services rendered to beneficiaries. These providers included approximately 9,300 physicians and physician groups, 2,800 hospitals, 1,250 clinics, and 2,650 other providers, such as therapists and other health care personnel, ambulance services, and medical equipment suppliers.

Our payment arrangements with hospitals generally are made using one of two general approaches: (1) a prospective average per diem payment based on the hospitals' historical and projected costs and (2) reasonable charges for service. All payment arrangements are monitored to evaluate whether the amounts paid are equitable in terms of the hospitals' needs and amounts paid by other categories of patients for the same services.

The funds are presently experimenting with alternative approaches such as prospective payments to hospitals based on their costs per admission rather than the present per-diem basis and with capitation payments for ambulatory services.

RELATIONSHIP OF PAYMENT MECHANISM TO FORCES CONTRIBUTING TO INCREASED HOSPITAL COSTS

Many theories have been advanced to explain the recent inflation in hospital costs. Two characteristics of the hospital economic environment underlying some of the theories are (1) the relative weakness of the competitive market system within the health delivery environment as an incentive for efficiency; and (2) the growth of third-party financing for hospital services.

Emphasis has been placed on the reimbursement mechanism because the present retroactive actual cost reimbursement system used by medicare and most third parties is not an effective substitute pricing mechanism for providing efficiency incentives.

Rather, the cost system is one of the basic contributing factors to increased hospital costs. It introduces few financial constraints into the decisionmaking process within hospitals. It neither rewards decisionmakers for efficient management of resources nor does it provide a basis for holding them accountable for such management.

Inflationary pressures result in higher costs in at least three ways. First, higher costs per unit of output can result from use of increased quantities of inputs per unit. Two measures of input quantities are the inflation adjusted value of capital assets and the number of employee full-time equivalents per unit of output. Similar measures can be used for inputs such as supplies and other services.

Second, inflation per unit of output can result from, increased costs of inputs. General inflation in the economy affects the cost of inputs used in the hospital's production process just as it does other industries. Some input costs for the hospital, however, may not follow the pattern of general price inflation. For instance, the average wages paid by hospitals have increased more than general wage levels over the past decade. More expensive inputs may also be related to improved technology and justified as being more effective or improving the quality of care.

Third, inflation of total hospital costs can be caused by increased utilization of hospitals by a given size population. Utilization is commonly measured by the patient-day rate or admission rate for a given population. Another factor of hospital utilization, however, is the scope of services offered. Outpatient clinical services, extended care services, and social services are examples of the many which have been added to the scope of hospital services in recent years.

The point to be made is that all proposals for cost containment, including those regarding the reimbursement mechanism, may be directed at very specific causes of inflation in any one or any combination of the more general areas just discussed—hospital utilization, input quantities, and input prices.

Furthermore, incentives can be directed at decisionmakers controlling hospitals, at physicians, or at patients. An incentive can work positively by setting rewards for resisting inflationary pressures or it can work negatively by setting penalties for not doing so.

Any use of the reimbursement mechanism to increase efficiency, to limit demand, or to limit the capacity or incentive to meet demand, forces specific normative definitions of efficiency and of "excess demand" and "need" for hospital care. It implies certain efficiency goals and related allocative priorities for use of resources within the hospital, and for alternative uses within the broader health care system.

We believe that payment mechanisms established by ourselves and other third-party agencies can contribute to the more efficient production and delivery of health care services. We do not believe, however, that the payment mechanism by itself is a panacea for achieving these limited goals or for solving other problems. The hospital payment mechanism is only one part of the total health care delivery system. An overall strategy dealing with the entire system must be developed in such a way that the various components are complementary and supportive of each other in terms of meeting specific priorities and objectives.

CRITERIA FOR EVALUATING ALTERNATIVE APPROACHES TO PAYMENT MECHANISMS

When designing or recommending changes to payment mechanisms, one is immediately faced with different notions of efficiency and the need to balance these and other conflicting objectives. Does the goal to limit hospital inflation conflict, for example, with a goal of the hospital and/or the society-at-large to maintain or improve the quality of care? Efficiency goals may require a tradeoff between hospital costs and personal costs to patients. Is the notion of efficient use of resources to be limited to minimizing the hospital's production costs, or to limiting total medicare benefit payments, or is efficiency to be perceived in terms of meeting the broader health- and non-health-related objectives of a specific community?

For these reasons, a reimbursement mechanism should be designed in terms of a set of specific objectives assigned to it. We suggest that there are at least five objectives which should appropriately be assigned to a hospital reimbursement system.

1. ENCOURAGE PRODUCTION EFFICIENCY IN HOSPITALS

Whatever the appropriate outputs of a hospital may be, and regardless of who determines them, hospital decisionmakers should have stronger incentives to produce those outputs at the least possible cost. The production process they establish should combine units of input to produce the maximum feasible quantity of a defined output. The least amount of each required input should be used and slack resources should be minimized.

Hospitals should also consider the relative costs of those inputs and choose that combination of inputs which minimize input costs. For example, capital equipment should not replace labor in the production process if labor can produce the same output at lower cost.

2. ENCOURAGE ALLOCATIVE EFFICIENCY WITHIN THE HOSPITAL AND WITHIN THE HEALTH CARE DELIVERY SYSTEM

Perfect allocative efficiency can be defined as attaining the optimal mix of outputs, each of which is produced at its optimal volume. The optimal mixes and volumes are those which minimize the cost of the total output of all producers.

In hospitals, volume variables include staffing levels and capital allocations. Service variables relate to the type and scope of services produced. Such efficiency should be encouraged in terms of producing units within a single hospital, between hospitals, and between hospitals and other units of the health care delivery system. Hospitals can optimize the scale of productive units and the mix of outputs by sharing or merging services and by specializing in certain outputs.

3. MINIMIZE THE NEED FOR EXTERNAL ADMINISTRATIVE AND STRUCTURAL CONTROLS OF THE HOSPITAL SYSTEM BY INTRODUCING ECONOMIC INCENTIVES

Where administrative and/or structural controls are used, support them through the payment mechanism.

This objective explicitly asserts that controlling the "flow of dollars" into the hospital system through the payment mechanism is aviable approach to attaining some health delivery goals and it is also preferred over other control devices. It also recognizes the limits of such an approach and, in those cases, designs the reimbursement system to be supportive of, or neutral to, alternative devices.

Mr. Cotter. Excuse me, Mr. Raino. We have just gotten a notification that there is a vote on the floor. Would you suspend for a few moments to give us an opportunity to go over and vote?

We will be right back.

[Whereupon a brief recess was taken.]

Mr. Cotter. The committee will come to order.

Mr. Raino, you may resume.

Mr. Raino. Mr. Chairman, I was about to discuss the fourth objective that we think could properly be set for a reimbursement system. That is, to minimize the existing or potential inequities that may be related to the payment mechanism.

The existence of large third-party financing agencies combined with the diversity of payment systems creates inequities in the sharing of total hospital costs. Some third parties are able to bargain with hospitals more effectively than others. The self-pay patient has little or no bargaining power and may pay more for the same service.

Inequities also exist between groups of hospitals and between their respective communities. Under the present system, an efficient hospital or efficient group of hospitals is not allowed to retain the rewards of their efficiency.

The "savings" are realized by the third-party agencies serving the community. Some of these savings may be returned to the community in the form of lower premiums or taxes, but they are generally spread throughout the entire area served by the third-party agency, including those in which hospitals are less efficient.

Citizens and hospitals in one area subsidize inefficiency or higher quality of care in another area.

5. DISCOURAGE OVERUTILIZATION OF HOSPITAL FACILITIES

Patient days and the number of intermediate services rendered are inputs to the hospital production process. Objectives relating to such inputs are included in the production efficiency objective previously stated.

Similarly, allocative efficiency objectives include optimizing the output of hospitals relative to nursing homes, ambulatory visits, and other health care resources.

Neither of these efficiency objectives, however, say anything about the nature of the demand which presents itself and is accepted by the hospital.

This fifth objective, then, deals with the concept of "unnecessary" demand or "overutilization" of health resources.

Severe problems exist in defining "unnecessary" and "excess" demand. That it exists to some degree, however, is generally accepted.

A reimbursement mechanism should not encourage such utilization, and ideally would provide an incentive for health care professionals to define and resist it.

Having defined our objectives for such a system, what are the characteristics of such a system that would support these objectives?

1. THE SYSTEM SHOULD HAVE UNIVERSAL APPLICATION TO ALL PATIENTS REGARDLESS OF PAYMENT SOURCE

Cost ceilings and target incentive rates such as those contained in S. 3205 and H.R. 13080, bills introduced by Senator Talmadge and Representative Duncan respectively, provide for potentially effective constraints on rising hospital costs.

The constraints are weakened, however, to the extent that a hospital is able to recover unreimbursed costs from one category of patients by passing them on to another patient group.

The self-pay patient and those third-party agencies with little leverage in a particular hospital are asked by the hospital to pay full charges which are set at a level designed to generate all its revenue requirements.

Although the constraints achieve the objectives of reducing the Federal medicare dollar outlays, they do little to reduce the total cost of providing hospital care. Costs are merely shifted to nonmedicare patients.

To be equitable and optimally effective in providing efficiency incentives a reimbursement system should be universally applicable to all patients of a particular hospital.

The Talmadge and Duncan proposals take an important step in this direction by putting both medicare and medicaid hospital reimbursement on the same basis.

This may have an adverse effect, however, if it results in a hospital attempting to recover even more unreimbursed costs by increasing its charges.

2. THE SYSTEM SHOULD SET PAYMENT RATES PROSPECTIVELY WITH NO RETROACTIVE ADJUSTMENTS

Rates set prior to the hospital actually rendering the services establish a budget constraint for the hospital for the period of time the rates are to apply.

Although changes in the rates may be made by the ratesetting agency at any time for significant changes in the utilization or certain cost elements beyond the hospital's control, there should be no retroactive payments and hospitals should be paid the rates regardless of the costs they actually incur.

3. THE UNITS ON WHICH PROSPECTIVE RATES ARE BASED SHOULD DIFFERENTIATE BETWEEN OUTPUTS

I was very interested to hear the testimony of Mr. Olson where he discussed the payment units. This gets at the same point that I will probably express in a little different way.

The typical method of payment used by medicare and other third-party agencies aggregate a hospital's costs and total patient-days to determine an average per diem rate.

This rate does not provide meaningful information as to the relative efficiency of hospitals in rendering comparable services or as to the reasonableness of such rates.

The difficulty arises from the problems of adequately defining and comparing the outputs of hospitals. The scope of services offered by a hospital, the quality of those services, the characteristics of the patients serviced and the conditions they present to the hospital for treatment are all variables which determine the hosptial output.

By aggregating patient-days for all hospitals in a defined category in order to establish a target rate, as proposed in the two bills mentioned, differences in service mix, patient mix and quality between hospitals in the category are not taken into account in establishing the reasonableness of the rate for a particular hospital.

Furthermore, the patient-day unit does not permit recognition of the differences in the care received by groups of patients within the same hospital.

The recent debate on the medicare "nursing differential" pointed up this problem. Using the patient-day as the payment unit also builds in an incentive for the hospital to maximize the total days in order to maximize total revenue.

The proposed legislation seems to address these problems by limiting the target rate to routine costs, by the scheme used in grouping hospitals, and by monitoring changes in these variables.

Alternatives to the patient-day as the payment unit are available that would support these other controls and eliminate the incentive to artificially increase the volume of patient-days.

One such alternative is to establish charge schedules for specific services such as for each diagnostic test, each hour of operating room time, or for each day of routine room, board and nursing care.

Such schedules are presently being reviewed together with supporting budget data for each hospital by State review agencies established in some States and by third-party agencies.

While such an approach has the potential of reducing the equity problems caused by hospital differences, it carries the incentive for hospitals to increase the quantity of these intermediate services.

Another alternative approach is to establish an average target rate for types of hospital admissions or "cases" with each type defined by diagnosis and patient characteristics.

The technology for defining cases in this way exists but is not presently applied to reimbursement except in experimental settings.

Target rates can be established by rate setting agencies using charge data for each type case in an area or on the basis of cost data, although present hospital cost allocation procedures are probably not sophisticated enough to give reliable rates based on such cost data.

Such a system, however, would certainly motivate hospitals to develop the necessary cost-finding procedures.

The use of diagnostically defined case types rather than patient-days as the payment unit would be compatible with other elements of Representative Duncan's and Senator Talmadge's legislation.

The impact of their proposals could be increased since use of the case type payment unit would facilitate bringing other hospital costs under the target rates in addition to the propose routine operating costs.

4. THE RESPONSIBILITY AND AUTHORITY FOR DETERMINING RATES AND OTHERWISE ALLOCATING AVAILABLE RESOURCES BETWEEN HOSPITALS IN A COMMUNITY SHOULD BE PLACED WITHIN THE COMMUNITY

State or local rates review agences should also have the responsibility and authority to redirect public funds, including those requested for capital replacement, away from unneeded facilities and services.

They should be required to act on the basis of the information received from local professional services review organizations and health system agencies serving their area.

The agency should also assure that each hospital adopt a standard system of cost accounting and submit annual budgets to support the rate review process.

Adoption of these concepts would require a significant redefinition of "reasonable cost" as presently applied by medicare.

It would also, from the viewpoint of administrative feasibility, mean delegation of the ratesetting function to local or State rate regulating agencies.

Delegation of this responsibility could be made within the framework of standard procedures, effectiveness criteria, ceilings and other limitations for which the ratesetting agency would be held responsible.

Federal matching funds can also be used, as proposed by Senator Talmadge and Representative Duncan, as an incentive for an effective ratesetting process.

The Health and Retirement Funds have developed over the past 2 years an automated Medical Information and Evaluation System called MINES.

This system is designed to: (1) Review the contents of provider invoices and make appropriate payments. (2) to collect information from the payment process to be used for utilization review, cost control, and case followup purposes.

The system will give the funds the data base necessary to better experiment with alternative payment mechanisms such as those we have suggested.

A summary description of our system is attached to the typed copy of my testimony as appendix I. As we proceed in these efforts we would be pleased to share our findings with Congress and others.

[The prepared statement and appendix follow:]

STATEMENT OF DOMINIC B. RAINO, STAFF DIRECTOR, HEALTH SERVICES DEPARTMENT, UNITED MINE WORKERS OF AMERICA HEALTH AND RETIREMENT FUNDS

Mr. Chairman, the United Mine Workers of America Health and Retirement Funds are grateful for this opportunity to appear before this subcommittee to present testimony on the issues involved in rising hospital costs and possible revisions in the present retrospective cost reimbursement system used in the medicare program.

The health and retirement funds are successors to the original welfare and retirement fund established by the Krug-Lewis agreement in 1946. The funds provide health and pension benefits to a population of over 760,000 coal miners, retired and disabled miners, and their dependents, living in 48 of the 50 States, but concentrated in the coal field areas of Appalachia, the Upper Mississippi Valley, and the rural West. Of these three-quarters of a million people, about 118,000 are presently medicare enrollees, for whom the funds pay the medicare part A deductibles and coinsurance. We also pay for all part B services for these beneficiaries as a group prepaid practice plan dealing directly with the Social Security Administration.

The Funds are multi-employer joint Trusts established under Section 302 of the Taft-Hartley Act. The agreements under which we operate are adopted as part of the collectively-bargained wage agreements between the United Mine Workers of America, the Bituminous Coal Operators Association, the Association of Bituminous Contractors, and individual coal miner operators and coal haulers. Eligibility for, and level of benefits, and rates of payment from the signatory companies are established for the terms of the collective bargaining agreement by the Trusts' settlors. The Funds are administered by a three-member Board of Trustees. The present Trustees are Harry Huge, Chairman, appointed by the Union, C. W. Davis, appointed by the employers, and Paul R. Dean, a jointly-appointed neutral Trustee. The three Trustees are committed to act solely in the interests of the persons covered by the trusts, and are bound by the fiduciary responsibility established in the Employee Retirement Income Security Act of 1974.

As you know, coal mining is one of the most dangerous occupations in the United States, and it should therefore be no surprise that our population has a very high rate of medical problems which require professional care. The high incidence of disease and accidents, coupled with the traditionally poor access to medical care in the rural areas we serve, and compounded by other hardships of rural and mountain life, have made the 27 years of the funds' medical program a unique chapter in American health care. In 1975, the funds paid out almost $200 million for health care for our covered population, about $40 million of that for beneficiaries on medicare.

Our concern with rising health care costs and with the system used to pay for health care services derive from our purposes as stated in the Trust documents:

(1) Provide beneficiaries of the Trusts with quality health care;

(2) Improve the delivery of quality health care services;

(3) Assist beneficiaries in solving their health needs through education and prevention measures;

(4) Assist the beneficiaries, wherever practical, in improving their general health and living conditions.

These general goals are, however, constrained by the fixed level of income to the Funds set by the wage agreement, and by the responsibilities of the Trustees under ERISA to ensure the availability of benefits into the future. In this regard, we are in a position similar to the thousands of other jointly-administered Trusts established under Taft-Hartley and covered by ERISA.

While the Funds do not provide medical care directly to our beneficiaries, we also do not operate strictly as a third-party-payor. Rather, we see our role as both arranging, facilitating and paying for health care for our population, and as working with both providers of care and beneficiaries to control costs and improve the quality of care. The benefits we include are quite comprehensive—they include all physician care, both in and out of the hospital, hospital costs, and chronic care drugs. The major exclusions are dental care and routine eye care and eyeglasses. For those beneficiaries covered by Medicare, currently about 118,000 persons, we provide coverage for most of the costs not reimbursed by Medicare, including the deductibles and coinsurance. The burden of increased health care costs thus fall on the Trusts, not on our beneficiaries directly.

In 1974, the Funds made substantial payments to about 16,000 health care providers for services rendered to beneficiaries. These providers included approximately 9,300 physicians and physician groups, 2,800 hospitals, 1,250 clinics, and 2,650 other providers, such as therapists and other health care personnel, ambulance services, and medical equipment suppliers.

Our payment arrangements with hospitals generally are made using one of two general approaches: 1) a prospective average per diem payment based on the hospitals' historical and projected costs; and 2) reasonable charges for service.

All payment arrangements are monitored to evaluate whether the amounts paid are equitable in terms of the hospitals' needs and amounts paid by other categories of patients for the same services.

The Funds are presently experimenting with alternative approaches such as prospective payments to hospitals based on their average costs per admission rather than the present per diem basis and with capitation payments for ambulatory services.

RELATIONSHIP OF PAYMENT MECHANISM TO FORCES CONTRIBUTING TO INCREASED HOSPITAL COSTS

Many theories have been advanced to explain the recent inflation in hospital costs. Two characteristics of the hospital economic environment underlying some of the theories are (1), the relative weakness of the competitive market system within the health delivery environment as an incentive for efficiency, and (2), the growth of third party financing for hospital services. Emphasis has been placed on the reimbursement mechanism because the present retroactive actual cost reimbursement system used by Medicare and most third parties is not an effective substitute pricing mechanism for providing efficiency incentives. Rather, the cost system is one of the basic contributing factors to increased hospital costs. It introduces few financial constraints into the decision making process within hospitals. It neither rewards decision makers for efficient management of resources nor does it provide a basis for holding them accountable for such management.

Inflationary pressures result in higher costs in at least three ways. First, higher costs per unit of output can result from use of increased quantities of inputs per unit. Two measures of input quantities are the inflation adjusted value of capital assets and the number of employee full time equivalents per unit of output. Similar measures can be used for inputs such as supplies and other services. Second, inflation per unit of output can result from increased costs of inputs. General inflation in the economy affects the cost of inputs used in the hospital's production process just as it does other industries. Some input costs for the hospital, however, may not follow the pattern of general price inflation. For instance, the average wages paid by hospitals have increased more than general wage levels over the past decade. More expensive inputs may also be related to improved technology and justified as being more effective or improving the quality of care. Third, inflation of total hospital costs can be caused by increased utilization of hospitals by a given size population. Utilization is commonly measured by the patient day rate or admission rate for a given population. Another factor of hospital utilization, however, is the scope of services offered. Outpatient clinical services, extended care services, and social services are examples of the many which have been added to the scope of hospital services in recent years.

The point to be made is that all proposals for cost containment, including those regarding the reimbursement mechanism, may be directed at very specific causes of inflation in any one or any combination of the more general areas just discussed; hospital utilization, input quantities, and input prices. Furthermore, incentives can be directed at decision makers controlling hospitals, at physicians, or at patients. An incentive can work positively by setting rewards for resisting inflationary pressures or it can work negatively by setting penalties for not doing so.

Any use of the reimbursement mechanism to increase efficiency, to limit demand, or to limit the capacity or incentive to meet demand, forces specific normative definitions of efficiency and of "excess demand" and "need" for hospital care. It implies certain efficiency goals and related allocative priorities for use of resources within the hospital, and for alternative uses within the broader health care system.

We believe that payment mechanisms established by ourselves and other third party agencies can contribute to the more efficient production and delivery of health care services. We do not believe that the payment mechanism by itself is a panacea for achieving these limited goals or for solving other problems. The hospital payment mechanism is only one part of the total health care delivery system. An overall strategy dealing with the entire system must be developed in such a way that the various components are complementary and supportive of each other in terms of meeting specific priorities and objectives.

CRITERIA FOR EVALUATING ALTERNATIVE APPROACHES TO PAYMENT MECHANISMS

When designing or recommending changes to payment mechanisms, one is immediately faced with different notions of efficiency and the need to balance these and other conflicting objectives. Does the goal to limit hospital inflation conflict, for example, with a goal of the hospital and/or the society at large to maintain or improve the quality of care? Efficiency goals may require a trade off between hospital costs and personal costs to patients. Is the notion of efficient use of resources to be limited to minimizing the hospital's production costs, or to limiting total Medicare benefit payments, or is efficiency to be perceived in terms of meeting the broader health and non-health related objectives of a specific community?

For these reasons a reimbursement mechanism should be designed in terms of a set of specific objectives assigned to it. We suggest that there are at least five objectives which should appropriately be assigned to a hospital reimbursement system.

1. *Encourage production efficiency in hospitals.*—What ever the appropriate outputs of a hospital may be, and regardless of who determines them, hospital decision makers should have stronger incentives to produce those outputs at the least possible cost. The production process they establish should combine units of input to produce the maximum feasible quantity of a defined output. The least amount of each required input should be used and slack resources should be minimized. Hospitals should also consider the relative costs of those inputs and choose that combination of inputs which minimize input costs. For example, capital equipment should not replace labor in the production process if labor can produce the same output at lower cost.

2. *Encourage allocative efficiency within the hospital and within the health care delivery system.*—Perfect allocative efficiency can be defined as attaining the optimal mix of outputs, each of which is produced at its optimal volume. The optimal mixes and volumes are those which minimize the cost of the total output of all producers. In hospitals, volume variables include staffing levels and capital allocations. Service variables relate to the type and scope of services produced. Such efficiency should be encouraged in terms of producing units within a single hospital, between hospitals, and between hospitals and other units of the health care delivery system. Hospitals can optimize the scale of productive units and the mix of outputs by sharing or merging services and by specializing in certain outputs.

3. *Minimize the need for external administrative and structural controls of the hospital system by introducing economic incentives. Where administrative and/or structural controls are used, support them through the payment mechanism.*—This objective explicitly asserts that controlling the "flow of dollars"

into the hospital system through the payment mechanism is a viable approach to attaining some health delivery goals and it is preferred over other control devices. It also recognizes the limits of such an approach and, in those cases, designs the reimbursement system to be supportive of or neutral to alternative devices.

4. *Minimize existing or potential inequities that may be related to the payment mechanism.*—Inequities exist between purchasers of hospital services. The existence of large third party financing agencies combined with the diversity of payment systems creates inequities in the sharing of total hospital costs. Some third parties are able to bargain with hospitals more effectively than others. The self-pay patient has little or no bargaining power and may pay more for the same service.

Inequities also exist between groups of hospitals and between their respective communities. Under the present system an efficient hospital or efficient group of hospitals is not allowed to retain the rewards of their efficiency. The "savings" are realized by the third party agencies serving the community. Some of these savings may be returned to the community in the form of lower premiums or taxes, but they are generally spread throughout the entire area served by the third party agency, including those in which hospitals are less efficient. Citizens and hospitals in one area subsidize inefficiency or higher quality of care in another area.

5. *Discourage overutilization of hospital facilities.*—Patient days and the number of intermediate services rendered are inputs to the hospital production process. Objectives relating to such inputs are included in the production efficiency objective previously stated. Similarly, allocative efficiency objectives include optimizing the output of hospitals relative to nursing homes, ambulatory visits, and other health care resources. Neither of these efficiency objectives, however, say anything about the nature of the demand which presents itself and is accepted by the hospital. This fifth objective, then, deals with the concept of "unnecessary" demand or "overutilization" of health resources.

Severe problems exit in defining "unnecessary" and "excess" demand. That it exists to some degree, however, is generally accepted. A reimbursement mechanism should not encourage such utilization and ideally would provide an incentive for health care professionals to define and resist it.

Characteristics of a hospital reimbursement system that would support these objectives are as follows:

1. *The system should have universal application to all patients regardless of payment source.*—Cost ceilings and target incentive rates such as those contained in S. 3205 and H.R. 13080 (Bills introduced by Senator Talmadge and Representative Duncan respectively), provide for potentially effective constraints on rising hospital costs. The constraints are weakened, however, to the extent that a hospital is able to recover unreimbursed costs from one category of patients by passing them on to another patient group. The self-pay patient and those third party agencies with little leverage in a particular hospital are asked by the hospital to pay full charges which are set at a level designed to generate all its revenue requirements. Although the constraints achieve the objectives of reducing the federal Medicare dollar outlays, they do little to reduce the total cost of providing hospital care. Costs are merely shifted to non-Medicare patients.

To be equitable and optimally effective in providing efficiency incentives a reimbursement system should be universally applicable to all patients of a particular hospital. The Talmadge and Duncan proposals take an important step in this direction by putting both Medicare and Medicaid hospital reimbursement on the same basis. This may have an adverse effect, however, if it results in a hospital attempting to recover even more unreimbursed costs by increasing its charges.

2. *The system should set payment rates prospectively with no retroactive adjustments.*—Rates set prior to the hospital actually rendering the services establish a budget constraint for the hospital for the period of time the rates are to apply. Although changes in the rates may be made by the rate setting agency at any time for significant changes in utilization or certain cost elements beyond the hospital's control, there should be no retroactive payments and hospitals should be paid the rates regardless of the costs they actually incur.

3. *The units on which prospective rates are based should differentiate between outputs.*—The typical method of payment used by Medicare and other third party agencies aggregate a hospital's costs and total patient days to deter-

mine an average per diem rate. This rate does not provide meaningful information as to the relative efficiency of hospitals in rendering comparable services or as to the reasonableness of such rates. The difficulty arises from the problems of adequately defining and comparing the outputs of hospitals. The scope of services offered by a hospital, the quality of those services, the characteristics of the patients serviced and the conditions they present to the hospital for treatment are all variables which determine the hospital output.

By aggregating patient days for all hospitals in a defined category in order to establish a target rate, as proposed in S. 3205 and H.R. 13080, differences in service mix, patient mix and quality between hospitals in the category are not taken into account in establishing the reasonableness of the rate for a particular hospital. Furthermore, the patient day unit does not permit recognition of the differences in the care received by groups of patients within the same hospital. The recent debate on the Medicare "nursing differential" pointed up this problem. Using the patient day as the payment unit also builds in an incentive for the hospital to maximize the total days in order to maximize total revenue.

The proposed legislation seems to address these problems by limiting the target rate to routine costs, by the scheme used in grouping hospitals, and by monitoring changes in these variables. Alternatives to the patient day as the payment unit are available that would support these other controls and eliminate the incentive to artificially increase the volume of patient days.

One such alternative is to establish charge schedules for specific services such as for each diagnostic test, each hour of operating room time, or for each day of routine room, board and nursing care. Such schedules are presently being reviewed together with supporting budget data for each hospital by rate review agencies established in some states and by third party agencies. While such an approach has the potential of reducing the equity problems caused by hospital differences, it carries the incentive for hospitals to increase the quantity of these intermediate services.

Another alternative approach is to establish an average target rate for types of hospital admissions or "cases" with each type defined by diagnosis and patient characteristics. The technology for defining cases in this way exists but is not presently applied to reimbursement except in experimental settings. Target rates can be established by rate setting agencies using charge data for each type case in an area or on the basis of cost data, although present hospital cost allocation procedures are probably not sophisticated enough to give reliable rates based on cost data. Such a system, however, would certainly motivate hospitals to develop the necessary cost finding procedures.

The use of diagnostically defined case types rather than patient days as the payment unit would be compatible with other elements of Representative Duncan's and Senator Talmadge's legislation. The impact of their proposals could be increased since use of the case type payment unit would facilitate bringing other hospital costs under the target rates in addition to the proposed routine operating costs.

4. *The responsibility and authority for determining rates and otherwise allocation available resources between hospitals in a community should be placed within the community.*—State or local rate review agencies should also have the responsibility and authority to redirect public funds, including those requested for capital replacement, away from unneeded facilities and services. They should be required to act on the basis of information received from local Professional Services Review Organizations and Health Agencies serving their area. The agency should also assure that each hospital adopt a standard system of cost accounting and submit annual budgets to support the rate review process.

Adoption of these concepts would require a significant redefinition of "reasonable cost" as presently applied by Medicare. It would also, from the viewpoint of administrative feasibility, mean delegation of the rate setting function to local or state rate regulating agencies. Delegation of this responsibility could be made within the framework of standard procedures, effectiveness criteria, ceilings and other limitations for which the rate setting agency would be held responsible. Federal matching funds can also be used, as proposed by Senator Talmadge and Representative Duncan, as an incentive for an effective rate setting process.

The Health and Retirement Funds have developed over the past two years an automated Medical Information and Evaluation System called MINES. This system is designed to: (1) review the contents of provider invoices and make appropriate payments, and (2) to collect information from the payment process to be used for utilization review, cost control, and case follow-up purposes. The system will give the Funds the data base necessary to better experiment with alternative payment mechanisms such as those we have suggested. A summary description of our system is attached to the typed copy of my testimony as Appendix I. As we proceed in these efforts we would be pleased to share our findings with Congress and others.

APPENDIX I

United Mine Workers of America Health and Retirement Funds

THE MINES SYSTEM

Payment and Control of Health Care Expenditures

Historically, cost control of health care expenditures has been exercised at two levels. First, individual invoices received are screened, and what appear to be excessive charges are returned for clarification or adjustment. "Excessive" has been a judgment based on knowledge of past charges for similar services and is more recently based in part on schedules developed and used by Medicare. There is not as yet, however, a single measure to be used to define an excessive fee. A second tool of cost control is that of the closed provider list. In theory, any provider consistently overcharging (however defined) can be removed from the list of approved providers of health services. In practice, however, the limited availability of health services in many areas seriously limits the viability of this option.

The above methods are used to control cost incurred on a fee for service or charge basis. An alternative arrangement with physicians is a retainer agreement specifying a monthly fee for any and all services rendered to Funds' beneficiaries. The fee is adjusted according to the portion of the provider's time allocated to beneficiaries' needs.

Although the foregoing procedures have been effective to a certain degree, the Trustees have approved the development of a highly sophisticated computerized medical payment and data gathering system which will substantially increase the Funds ability to monitor and control health related expenditures.

The system, called MINES (Medical Information and Evaluation System), has two major purposes: (1) to review the contents of provider invoices and make payment where appropriate, and (2) to collect information from the payment process to be used for utilization review, cost control, and case follow-up purposes. The automated system will substantially reduce the time required for processing of medical invoices and will therefore permit payment to providers of medical services more quickly than is now possible. In addition to reducing processing time, each phase of MINES has a major role in identifying and curtailing excessive fees and other charges.

Before an invoice is approved for payment, it will be reviewed to verify that: (1) the patient is an eligible beneficiary, (2) the physician or hospital is an approved provider, (3) prescribed drugs are on the Basic Drug List, and (4) procedures were performed in an acceptable place of service, and are covered by the Funds. Any charges not meeting the above tests will be rejected.

In addition, all charges will be compared to a billing standard to determine the validity of the amount shown for that procedure and provider. When a fee is greater than the standard, it will be held for special review by medical personnel and will generally be rejected.

The above procedures will control costs at the individual invoice level.

Data collected by the invoice processing component of the system will be summarized and used to monitor costs and services on a more comprehensive scale. Information available will include analysis of individual providers according to variables such as number of diagnostic procedures per visit, number, types and extent of hospital admissions, number of injections and costs of hospitalization; analysis of individual beneficiaries according to total visits, total expenditures, number of providers visited, and types of admissions; and analysis of individual drug providers according to the amount charged as compared to a standard drug cost for each generic drug category provided.

These data will provide factual analysis of costs based on predefined standards, and will form the basis for controlling future excesses and possible abuses.

The MINES system will also provide for improved patient care and monitoring of services through: (1) patient profiles showing services received by all beneficiaries in one family over a specific period of time; and (2) follow-up on patients having specific illnesses or injuries from selected lists prepared at the request of field office personnel.

THE SUR SUBSYSTEM

Surveillance and Utilization Review

One of the key elements of the Funds' health program traditionally has been active involvement of Funds' staff in the health care system to insure the delivery of high-quality care consistent with control of health costs. From its inception, the Funds has viewed its role as being more than simply paying for health care, but as a facilitator of access to care and as a monitor of the quality of that care. As an aid to this effort, and with the data made available by the MINES system, the Funds has now developed a system of Surveillance and Utilization Review (SUR) which will provide Funds' staff in the field with the tools to prioritize provider monitoring, and provide both field and Washington staff with the ability to report on system performance and improvement.

Establishment of a system to monitor provider quality involves two steps—the definition of indicators of quality care, and the establishment of acceptable values on these indicators. These ideally require a pre-existing data-base which can be used to test the validity of the selected indicators and to validate the norms suggested by expert panels. In the Funds' case, with no such data-base prior to implementation, the choice was made to select variables which appear to have relevance to the quality of health care, and to avoid the norm-setting problem by allowing nominal behavior to be initially defined by the data themselves.

Essentially, this means that similar providers will be compared with each other to define a range of practice on these variables. One end of the ranking presumably denotes more acceptable behavior, while the other end is less acceptable. On the basis of this ranking, the field staff will be able to select those providers most deviant from the norm defined by the range, and target them for follow-up.

SUR variables will be calculated quarterly, with a separate annual report. In addition to the reports on individual variables, a summary of provider rankings on all variables is also produced. To insure the effective use of the reports in improving the quality of health care, a review system will be established to monitor and guide regional action on SUR. In addition, a concerted effort to validate the selected variables, and to insure their reliability, will be undertaken.

The following is a list of the variables which will be calculated for each provider:

Percent Admissions With Vague Diagnoses.
Average Therapeutic Injections Per Visit.
Percent Admissions With Common Surgical Procedures.
Admissions Per 100 Visits.
Percent Admissions With Complications.
Average Diagnostic Procedures Per Visit.
Percent Admissions With Special Interest Procedures.
Average Length of Stay For Special Interest Procedures.
Average Hospitalization Cost—Special Interest Procedures.
Percent Admissions With Special Interest Diagnoses.
Average Length of Stay For Special Interest Diagnoses.
Average Hospitalization Cost—Special Interest Diagnoses.
Average Visits Per Beneficiary.

Mr. Cotter. Thank you for a fine presentation.

Are there any questions? Mrs. Keys?

Mrs. Keys. No.

Mr. Cotter. I have no questions.

Thank you, once again.

Our next witness will be Mr. Roger Lipitz, National Council of Health Care Services.

STATEMENT OF ROGER C. LIPITZ, PRESIDENT, NATIONAL COUNCIL OF HEALTH CARE SERVICES

Mr. Lipitz. Mr. Chairman, members of the subcommittee, I am president of the National Council of Health Care Services and chairman of the board of Medical Services Corporation, a company which owns and operates proprietary nursing facilities.

On behalf of the council, I appreciate this opportunity to appear before you today to discuss the shortcomings of the medicare reimbursement system as it applies to long-term care, and possible revisions in the program.

The national council represents a select group of proprietary multifacility health care companies owning and/or managing nursing homes, hospitals, psychiatric facilities, rehabilitation centers, and day care centers.

Mr. Chairman, we are aware that it was your intent to focus on hospitals in these hearings.

Mr. COTTER. Mr. Lipitz, would you suspend for a few minutes? We have another vote. We will be back as quickly as we can.

[A brief recess was held for voting purposes.]

Mr. COTTER. The committee will come to order.

Mr. Lipitz, you may resume.

Mr. LIPITZ. Thank you.

As I was saying, nursing homes are too frequently lumped with hospitals for statistical purposes and again when legislation is considered, though, Mr. Chairman, I digress from my written statement for a minute.

Long-term care is a small component of the medicare program. It is a substantial component of the medicaid program. In many respects, the way medicare goes is the way medicaid seems to follow, even though it is administered in the States; the States very often emulate HEW in the development of their programs.

The test for reasonableness and precedents set for hospitals are often mistakenly applied to nursing homes. We are not in favor of this approach, for the operation, patient load, and mix in nursing homes are distinctly unlike hospitals.

We ask that you take this into consideration in any of your committee's deliberations.

Two weeks ago in Chicago, the National Council of Health Care Services testified on the reasons for rising costs in nursing homes before the Council on Wage and Price Stability.

I would like to submit our testimony for the record and give a brief summary of what we feel are the three main factors responsible for increasing costs in the nursing home industry.

Mr. COTTER. Without objection, it will be admitted.

Mr. LIPITZ. These factors are: (1) Proliferation of Federal regulations and requirements, (2) increases in Federal minimum wage levels, (3) payment mechanisms which offer no incentives for cost containment.

The nursing home industry today is a prime example of a totally regulated industry. Nearly 70 percent of the patients in nursing homes are funded through medicare and medicaid, which do not reimburse the full cost of providing services for their patients, but at the same time increase costs unnecessarily.

The combination of State and Federal regulations, while being duplicative, inefficient and confused, has been a major contributor to the increase in nursing home costs.

The consequences of meeting the more than 1,000 Federal and State standards for staffing, services, building construction, et cetera, is evidenced in higher costs for the medicare and medicaid certified homes versus noncertified nursing homes—$21.17 per patient day versus $14.03 per patient day.

This is based on information developed by HEW itself.

The effect of having two separate programs for long-term care with differing requirements, standards and reimbursement methodologies, has been to increase costs tremendously without bringing about a corresponding increase in the quality or number of services to beneficiaries.

As an example, we have estimated that in nursing homes the cost of report preparation alone for medicare and medicaid totals more than $22 million annually.

Our solutions to these problems stated briefly are the consolidation of programs, standards and requirements, cost benefit analysis of existing and future regulations, and the elimination of those regulations which are duplicative and ineffective.

Mr. Chairman, I won't go into detail on the impact of increases in the minimum wage levels. The statement we gave to the Council on Wage and Price Stability did that.

Suffice it to say that 60 percent of our costs are attributable to labor. This, when combined with the fact that 70 percent of facility's income is controlled by medicare and medicaid, means that any federally mandated changes in manpower standards or wages have tremendous impact on a nursing home's costs.

The method of reimbursing nursing home services can greatly affect the inflation of health care costs.

Much has been said about the inefficiencies and waste in the medicare program which contribute to inflation. The reimbursement system which is cost based, is also inherently inflationary.

There are no incentives for cost containment, and in fact, there is a negative incentive for keeping the patient in bed and dependent upon the medical services he receives.

The Government's response to these program defects has been not to correct the problem but rather to pile more and more regulations, surveys and reporting forms upon us, which in turn increases our costs.

The real solution to this problem is the major revision of the medicare payment system.

Mr. Chairman, I wish I could say that there were some good examples of prospective reimbursement systems in long-term care which I could cite here today.

Unfortunately, this is not the case.

Section 222 of Public Law 92–603 required the Social Security Administration to carry out demonstration projects for innovative reimbursement systems in hospitals and long-term care facilities.

Today, 4 years after the law's enactment, we have no such projects in nursing homes. We, therefore, have no experience or data to draw upon as to the problems involved or cost savings which might result from such systems.

We strongly support experimentation in prospective payment methodologies. A prospective system would offer a solution to inflating health care costs by containing expenditures, while at the same time providing the incentive for nursing home administrators to manage efficiently and strive to come under budget.

We believe that the prospective system would be less difficult to implement in nursing homes than in hospitals, in that items of service, personnel needs, equipment, and plant requirements are much easier to forecast and to control.

We would ask, however, then that you not take any reimbursement systems as developed in or for hospitals and apply them across the board to nursing homes.

Nor should you evaluate the progress and success of such programs in hospitals and attribute the results as applicable to nursing homes. They very well may not be.

We believe that a solution has already been provided for the long-term care area in the form of final regulations to implement section 249 of Public Law 92–603.

These regulations permit States to develop cost-related prospective reimbursement systems for title XIX beneficiaries in nursing homes.

Public Law 92–603 also provides authority for the use of the medicaid payment system for medicare patients if it is a superior system.

Rather than lumping nursing homes in with any hospital reimbursement system you may be considering, we suggest that section 249, with some modification, is an appropriate vehicle to achieve your goals in this area.

Any other approach would merely confuse the issue.

Presently, nursing homes which participate in medicare and medicaid are coping with two payment methods, which is both a time-consuming and an expensive process.

Ideally, States or the Federal Government should offer several methods for reimbursement. These may be on a class, geographic, size, or individual basis with the facility choosing the one method under which it would be reimbursed for all public patients.

We strongly question the desirability of applying more than one reimbursement method in each facility as is presently the case.

Regarding ratesetting commissions, there has not been sufficient progress in this area to make a proper evaluation, particularly in long-term care.

We are presently attempting to measure the potential effects such a concept would have on our industry, but certainly do not endorse any wholesale mandating of ratesetting prior to gaining experience from working models.

We believe that section 249 permits adequate flexibility, and additionally under section 222, the authority still exists for prospective payment demonstration projects if HEW would only exercise it.

The National Council of Health Care Services has adopted a model payment system that would fulfill the requirements of sections 222 and 249, which I would like to submit to your committee.

Mr. COTTER. Without objection, it will be admitted.

Mr. LIPITZ. Our model ties reimbursement to the quality of care, an essential element, we believe, in any system.

Clifton, Gunderson & Co., a public accounting firm in Peoria, Ill., has developed a methodology for the implementation of the National Council's model and has recently submitted a proposal to HEW to actually carry out the implementation as a demonstration project under section 222.

I would like to submit their study for the record also.

Mr. COTTER. Without objection, it will be admitted.

[The material mentioned has been retained in the subcommittee files.]

Mr. Lipitz. Regarding S. 3205, we strongly support the intent of this bill as reflected in its title, the Medicare and Medicaid Administrative and Reimbursement Reform Act.

The present situation of overlapping authorities and unending regulations must be corrected. This can only be accomplished, however, if a single authority has the overall responsibility and accountability for: (1) Determining the acceptable scope and levels of service; (2) monitoring and assuring that the budgetary constraints are met for services rendered to beneficiaries.

On the reimbursement issue, as stated earlier, we believe the statutory authority presently exists under sections 222 and 249 for reimbursement experiments in nursing homes.

Thus, we agree with the scope of the Talmadge bill in limiting itself initially to prospective systems in hospitals. Such experimentation in hospitals and nursing homes is essential prior to the implementation of any national health insurance program.

However, the continued inaction of HEW in developing new systems of payments, particularly for long-term care facilities, may require the Congress to mandate the establishment of more efficient payment systems.

They don't seem to be willing to do it on their own.

A popular solution to the rising costs is the imposition of ceilings. In the health care area, ceilings are proposed for the whole industry on the basis of hospital and physician cost statistics.

We are firmly opposed to the application of any ceilings and believe that they would only create a tenuous artificial environment, and would result in only a temporary slowing of the rate of inflation and in reality offer only a short-term solution to increasing costs.

Furthermore, ceilings would be entirely unnecessary if prospective reimbursement were used.

Prospective reimbursement would afford providers the opportunity to know in advance what rate they will be assured of for the year, with no retroactive denials.

I might add that the State and Federal Governments would also know what they are going to pay.

States in turn would know how much they have to spend and adjust their rates and services accordingly.

Rather than impose arbitrary ceilings during the transition period to a prospective system, a more appealing and popular approach might be the application of incentives and disincentives under medicare for such items as increased occupancy and managerial efficiencies.

If fairly developed, one could not argue against them and they could have the same results as a ceiling.

Mr. Chairman, in conclusion we support initiatives such as yours and Senator Talmadge's in seeking innovative solutions to the problems which confront us.

Clearly the traditional methods have not worked because they have not tried to correct the system, but rather to restrict the output.

Insofar as nursing homes are concerned, we believe that statutory language is already in effect which would permit experimentation in innovative systems.

We would be grateful, however, for any assistance your subcommittee might render in assuring that these mandates are carried out.

Mr. Chairman, thank you for allowing us to appear before you today and we would be pleased to answer any questions you might have.

Mr. COTTER. Any questions, Mrs. Keys?

Mrs. KEYS. No.

Mr. COTTER. Mr. Chairman?

Mr. ROSTENKOWSKI. No.

Mr. COTTER. Thank you very much.

[The prepared statement and attachments follow:]

STATEMENT OF ROGER C. LIPITZ, ON BEHALF OF THE NATIONAL COUNCIL OF HEALTH CARE SERVICES

Mr. Chairman, members of the Subcommittee, my name is Roger Lipitz. I am President of the National Council of Health Care Services, and Chairman of the Board of Medical Services Corporation, a company which owns and operates proprietary nursing facilities. On behalf of the National Council of Health Care Services, I appreciate this opportunity to appear before you today to discuss the shortcomings of the Medicare reimbursement system as it applies to long term care, and possible revisions in the program.

The National Council of Health Care Services represents a select group of proprietary multi-facility health care companies owning and/or managing nursing homes, hospitals, psychiatric facilities, rehabilitation centers, and day care centers. As a condition of membership, the National Council's nursing home facilities are required to meet the accreditation standards for long term care set by the joint Commission on Accreditation of Hospitals. This assures that our members have met the very highest standards for quality care, standards which less than five percent of the industry have achieved.

Each member of the National Council is dedicated to seeking innovative approaches to the provision of quality patient care in the most appropriate and cost-effective setting.

Mr. Chairman, we are aware that it was your intent to focus on hospitals in these hearings, however, all too frequently, nursing homes are lumped together with hospitals for statistical purposes, and again when legislation is proposed. The tests for reasonableness and precedents set in hospitals are often mistakenly applied to nursing homes as well. We are not in favor of this approach for the operation, patient load and mix in nursing homes are distinctly unlike hospitals, and we ask that you take this matter into consideration in any of your Committee's deliberations. Until the time that this situation is corrected, we do want to provide our input.

Two weeks ago in Chicago, the National Council of Health Care Services testified on the reasons for rising costs in nursing homes before the Council on Wage and Price Stability. I would like to submit our testimony for the record and give a brief summary of what we feel are the three main factors responsible for increasing costs in the nursing home industry.

These factors are: (1) proliferation of Federal regulations and requirements, (2) increases in Federal minimum wage levels, and (3) payment mechanisms which offer no incentives for cost containment.

1. *Proliferation of Federal Regulations.*—The nursing home industry today is a prime example of a totally regulated industry. Nearly 70 percent of the patients in nursing homes are funded through Medicare and Medicaid, which do not reimburse the full cost of providing services for their patients.

The combination of State and Federal regulations, while being duplicative, inefficient, and confused, has been a major contributor to the increase in nursing home costs. The consequences of meeting the more than 1,000 Federal and State standards for staffing, services, building construction, etc., is evidenced in higher costs for the Medicare and Medicaid certified homes versus non-certified nursing homes ($21.17 per patient day versus $14.03 per patient day).[1]

The effect of having two separate programs for long term care with differing requirements, standards and reimbursement methodologies, has been to increase costs tremendously without bringing about a corresponding increase in the quality or number of services to beneficiaries.

---

[1] U.S. Department of Health, Education, and Welfare, Health Resources Administration, *Selected Operating and Financial Characteristics of Nursing Homes, U.S.: 1973–74 National Nursing Home Survey,* December 1975.

As an example, we have estimated that in nursing homes the cost of report preparation alone for Medicare and Medicaid totals more than $22 million annually.

Our solutions to these problems stated briefly are the consolidation of programs, standards and requirements, cost benefit analysis of existing and future regulations, and elimination of those regulations which are duplicative and ineffective.

2. *Wage Level Increases.*—The second reason for increasing costs in nursing homes is the Federally mandated increases in the minimum wage. Mr. Chairman, I won't go into detail on this subject since it is covered in our statement before the Council on Wage and Price Stability. Suffice it to say, the nursing home industry is extremely labor intensive with nearly 60 percent of our costs attributable to labor. This, when combined with the fact that 70 percent of a facility's income is controlled by Medicare and Medicaid, means that any Federally mandated changes in manpower standards or wages have tremendous impact on a nursing home's costs.

3. *Payment Mechanism.*—The method of reimbursing nursing home services can greatly affect the inflation of health care costs.

Much has been said about the inefficiencies and waste in the Medicare program which contribute to inflation. The reimbursement system which is cost-based, is also inherently inflationary. There are no incentives for cost containment, and in fact, there is a negative incentive for keeping the patient in bed and dependent upon the medical services he receives.

The Government's response to these program defects has been not to correct the problem, but rather to pile more and more regulations, surveys, and reporting forms upon us, which in turn increases our costs.

The real solution to this problem is the major revision of the Medicare payment mechanism. Something I believe, Mr Chairman, that your Committee is attempting to pursue here today.

PROSPECTIVE REIMBURSEMENT

Mr. Chairman, I wish I could say that there were some good examples of prospective reimbursement systems in long term care which I could cite here today. Unfortunately, this is not the case.

Section 222 of Public Law 92–603 required the Social Security Administration to carry out demonstration projects for innovative reimbursement systems in hospitals and long term care facilities. Today, four years after the law's enactment, we have no such projects in nursing homes. We, therefore, have no experience or data to draw upon as to the problems involved or cost savings which might result from such systems.

We strongly support experimentation in prospective payment methodologies. A prospective payment system would offer a solution to inflating health care costs by containing expenditures, while at the same time, providing the incentive for nursing home administrators to manage efficiently and strive to come under budget.

We believe that the prospective system would be less difficult to implement in nursing homes than in hospitals in that items of service, personnel needs, equipment, and plant requirements are much easier to forecast and to control. Additionally, the accounting systems in nursing homes are less complicated and are easier to adapt to the requirements of a Federal program, since 70 percent to 80 percent of the patients are supported through Medicare and Medicaid.

We would ask, however, that you not take any reimbursement systems as developed in or for hospitals and apply them across the board to nursing homes. Nor, should you evaluate the progress and success of such programs in hospitals and attribute the results as applicable to nursing homes.

We believe that a solution has already been provided for the long term care area in the form of final regulations to implement Section 249 of Public Law 92–603 issued on July 1, 1976. These regulations permit states to develop cost-related prospective reimbursement systems for Title XIX beneficiaries in nursing homes. P.L. 92–603 also provides authority for the use of the Medicaid payment system for Medicare patients if it is a superior system.

Rather than lumping nursing homes in with any hospital reimbursement system you may be considering, we suggest that Section 249 is an appropriate vehicle to achieve your goals in this area. Any other approach would merely confuse the issue.

OTHER PAYMENT METHODOLOGIES

Presently, nursing homes which participate in Medicare and Medicaid are coping with two payment methods, which is both a time consuming and an expensive process. Ideally, States or the Federal Government should offer several methods for reimbursement. These may be on a class, geographic, size, or individual basis with the facility choosing the one method under which it would be reimbursed for all public patients. We strongly question the desirability of applying more than one reimbursement method in each facility as is presently the case.

Regarding rate setting commissions, there has not been sufficient progress in this area to make a proper evaluation, particularly in long term care. We are presently attempting to measure the potential effects such a concept would have on our industry, but certainly do not endorse any wholesale mandating of rate setting prior to gaining experience from working models. We believe that Section 249 permits adequate flexibility; and additionally under Section 222, the authority still exists for prospective payment demonstration projects if HEW would only exercise it.

The National Council of Health Care Services has developed a model payment system that would fulfill the requirements of Sections 222 and 249, and which I would like to submit to your Committee. Our model ties reimbursement to the quality of care, an essential element, we believe, in any system. Clifton, Gunderson & Company, a public accounting firm in Peoria, Illinois, has developed a methodology for the implementation of the National Council's model and has recently submitted a proposal to HEW to actually carry out the implementation as a demonstration project under Section 222. I would like to submit their study for the record also.

MEDICARE AND MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT

Mr. Chairman, I would also like to submit our testimony on S. 3205, Senator Talmadge's bill, before the Senate Finance Committee's Subcommittee on Health.

We strongly support the intent of this bill a reflected in its title, the Medicare and Medicaid Administrative and Reimbursement Reform Act. The present situation of overlapping authorities and unending regulations must be corrected. This can only be accomplished, however, if a single authority has the overall responsibility and accountability for (1) determining the acceptable scope and levels of services, and (2) monitoring and assuring that the budgetary constraints are met for services rendered to beneficiaries.

On the reimbursement issue, as stated earlier, we believe the statutory authority presently exists under Sections 222 and 249 for reimbursement experiments in nursing homes. Thus, we agree with the scope of the Talmadge bill in limiting itself initially to prospective systems in hospitals. Such experimentation in hospitals and nursing homes is essential prior to the implementation of any national health insurance program.

CEILINGS

A popular "solution" to rising costs is the imposition of ceilings. In the health care area, ceilings are proposed for the whole industry on the basis of hospital and physician cost statistics. We are firmly opposed to the application of any ceilings and believe that they would only create a tenuous artificial environment, and would result in only a temporary slowing of the rate of inflation and in reality offer only a short term solution to increasing costs.

Furthermore, ceilings would be entirely unnecessary if prospective reimbursement were used. Prospective reimbursement would afford providers the opportunity to know in advance what rate they will be assured of for the year, with no retroactive denials. States in turn would know how much they have to spend and adjust rates and services accordingly.

Rather than impose arbitrary ceilings during the transition period to a prospective system, a more appealing and popular approach might be the application of incentives and disincentives under Medicare for such items as increased occupancy and managerial efficiencies. If fairly developed, one could not argue against them and they could have the same results as a ceiling.

CONCLUSIONS

Mr. Chairman, in summary, we support initiatives such as yours and Senator Talmadge's in seeking innovative solutions to the problems which confront us.

Clearly the traditional methods have not worked because they have not tried to correct the system, but rather to restrict the output.

Insofar as nursing homes are concerned, we believe hat statutory language is already in effect which would permit experimentation in innovative systems. We would be grateful, however, for any assistance your Subcommittee might render in assuring that these mandates are carried out.

Mr. Chairman, thank you for allowing us to appear before you today, and we would be pleased to answer any questions you might have.

NATIONAL COUNCIL OF HEALTH CARE SERVICES,
Washington, D.C.

The National Council of Health Care Services is a voluntary association of proprietary health care companies whose members own and manage nursing homes, hospitals, psychiatric facilities, clinics, child day care services and home health services.

The National Council was established in 1969 to provide a voice in Washington D.C. for multi-facility operations while at the same time providing its membership with information on the most current activities of Congress and the federal government. NCHCS membership has grown during this time to represent facilities comprising over 70,000 beds. Activities include the areas of congressional and governmental relations, information services and public relations.

A characteristic unique to the National Council is the requirement that its nursing facilities meet the standards for accreditation set by the Joint Commission on Accreditation of Hospitals, the only national health organization to do so. Accrediting standards of the Joint Commission surpass state licensing requirements and Medicare and Medicaid standards and compliance with this requirement means National Council members enjoy a special position in the provision of quality services in the long term care industry.

In early 1976 the National Council undertook the establishment of a consumer advisory panel to its Board of Directors to recommend ways the National Council can improve its services to the consumer. The panel will be meeting four times a year in Washington, D.C. and providing a valuable third voice to member facility management.

Following are the primary goals of the National Council of Health Care Services:

> Secure a better understanding of the role of privately owned facilities in providing quality health care at a reasonable cost.
>
> Stimulate competition, communication and cooperation among providers of health care and all who are concerned that Americans receive the best possible care.
>
> Support the use of management practices to help control costs of health care.
>
> Promote recognition of the vital role that financial and ethical incentives play in the delivery of health care services.
>
> Seek innovation in the health care system to improve its responsiveness to the public.
>
> Assist government to improve the standards of its health care programs, and to eliminate the inefficient, duplicative and conflicting regulations in these programs.

The National Council of Health Care Services has achieved a position in the vanguard of the long term care industry through its high standards and progressive programs and, as a result, has become an effective and respected voice for its members and for the multi-facility concept.

A PAYMENT SYSTEM FOR LONG TERM CARE INSTITUTIONAL SERVICES

NATIONAL COUNCIL OF
HEALTH CARE SERVICES
Suite 402/1200 Fifteenth St. N.W.
Washington, D.C. 20005

TABLE OF CONTENTS

Preface 3

Introduction 5

I. Common Objectives 7
  A. The Establishment of Quality Levels of Service 7
  B. The Encouragement of Efficiencies in the Delivery of Service 7
  C. The Encouragement of Orderly Growth 7
  D. Incentives for the Patient to Seek the Cost Effective Provider 7
  E. The Rewarding of Efficiencies 8
  F. Administrative Simplicity 8

II. Primary Principles of Payment 8
  A. Rates and Charges Must Be Determined Prospectively 8
  B. Rates and Charges Must Be Cost Related 8
  C. A Profit Must Be Allowed 9
  D. The Payment System Must Encourage Cost Containment 9
  E. All Rates Need to be Related to Patient Assessment 9
  F. An Allowance for the Cost of Capital 9
  G. The Application of a Quality Assurance Penalty 10
  H. In Establishing Rates for Facilities, Standard Costs Must Be Used Relative to Their Socio-Economic Areas, Size and Service 10
  I. The Availability of an Appeal Procedure 10

III. Methodology of Payment 10
  A. Service Cost Components 11
    1. Standard Services 11
    2. Capital 11
    3. Patient Services 13
    4. Ancillary Services 13
  B. Profit or Loss 13
  C. Administration 15
    1. Rate Determination Process 15
    2. Effective Period of Rate 15
    3. Public Disclosure 15
    4. Appeal Process 15

IV. Hypothetical Example 16

Second Printing

PREFACE

On October 17, 1972, the United States Congress passed P.L. 92-603, the "Social Security Amendments of 1972." This is the most extensive revision of the Social Security Act ever undertaken by Congress.

One of the most important revisions for skilled nursing and intermediate care facilities in the legislation is Section 249. Under this provision skilled nursing and intermediate care facilities participating in the Medicaid program would be paid on a "reasonable cost-related basis" as of July 1, 1976. The meaning of this terminology has been the subject of extensive discussions within the government, as well as the industry, since its enactment by Congress.

The National Council has conducted an extensive review of the payment systems presently being used to pay for services by the Medicaid, Medicare and private insurance carrier programs. This review also included an examination of the legislative history of Section 249 of P.L. 92-603.

Interviews and discussions were held with Federal and state officials, as well as accountants and representatives of the nursing home industry.

This paper is the culmination of the National Council's research effort to date. It should not be considered as being conclusive, but rather one of several possible approaches for meeting the statutory requirements of P.L. 92-603. It is the intent of the National Council to continue to modify and improve this system. Any comments or recommendations of the reader will be appreciated and carefully considered by the National Council.

This paper is, in short, an evolutionary step in the process of arriving at a payment system that the patient, taxpayer, government and provider can afford physically as well as fiscally.

The National Council is indebted to many members of the Health Care Profession. These include providers of long-term care services, government and Congressional officials, health economists, accountants, and state officials. The National Council would like to especially thank the members of its Payment for Services Task Force: Chairman—Sam Gunnerson, CPA, Turtle Creek Convalescent Centers, Inc.; James Meyer, Ph.D., ANTA Corporation; Dan Humphrey, CPA, Norman Hobbs and Company; Ken Garwood, CPA, American Health Care Association and Mark Brookner, CPA, National Living Centers.

Without their enthusiasm and untiring efforts, this paper would not have been possible.

Roger C. Lipitz
President of The National Council of Health Care Services

INTRODUCTION

The health delivery system in this country has been popularly viewed as being a dogmatic and monolithic structure. It has in turn been criticized as being inefficient, costly, unresponsive, inaccessible, and of delivering a poor quality of care.

This concept is a gross oversimplification of the true state of affairs. Our system is made up of a variety of components including institutional providers, individual professionals, health system planners, private and government finance programs, public and private payment systems, and quality assessment/monitor systems. Each of these components has a role, whose importance varies according to the needs of the patient.

Despite the apparent complexity of the system, there is one component, the payment mechanism, which is of importance to everyone regardless of their role. A great deal of attention has been centered on this component as a means of controlling the cost of health care services. It should be recognized that it also directly influences the quality of the product of each of the other components.

The impact of this system on the other components and most importantly their quality is determined not only by the amount of the payment but also by the methodology used to compute that amount. This methodology can be an incentive or a disincentive to the other components to perform successfully.

If our health delivery system has failed and is inefficient, it is to a large extent due to the methodology of our payment systems which rely on disincentives rather than incentives to control costs. This has caused an imbalance in the health delivery system which has produced increases in the cost of care while not providing a corresponding increase in the quality of health care services. This imbalance in the methodology of our payment systems must be corrected if the system as a whole is to function properly.

It is, therefore, the position of the National Council that government and private programs must adopt a payment system which is predicated on incentives. An effective payment system must balance incentives with disincentives to encourage the provider to meet the general goal of providing quality care at a reasonable cost.

I—COMMON OBJECTIVES

The fundamental principle of an effective payment system is the promotion of quality care at a reasonable cost. This can only be achieved if the health delivery system and the payment system are closely coordinated to attain a high degree of commonality of purpose. There are basically six goals which the health delivery system and the payment system should share:

A. The Establishment of Quality Levels of Service.
B. The Encouragement of Efficiencies in the Delivery of Service.
C. The Encouragement of Orderly Growth.
D. Incentives for the Patient to Seek the Cost Effective Provider.
E. The Rewarding of Efficiencies.
F. Administrative Simplicity.

Each of these must be present in an effective payment system for several reasons.

A. *The Establishment of Quality Levels of Service*

A clear definition of "quality care" is essential to the development of viable payment and delivery systems. The Council recommends that acceptable norms of service become the guides used in developing the system. These must be jointly developed and clearly defined not only by the governmental agencies responsible for enforcing standards, but also by those agencies that are responsible for paying for the services. This would help assure that any changes in standards are properly translated into payment increases or decreases. In addition, it has proven unworkable as well as illogical to require standards from a provider in excess of what a government agency is willing or able to pay.

B. *The Encouragement of Efficiencies in the Delivery of Service*

In order for the health delivery system to be efficient in terms of both the services delivered and their costs, services must be delivered at the lowest possible entry point. Some have argued that there is presently enough waste in our system to more than cover the needed increase in quality of services.

One of the wastes in our present system is that it has been designed to discriminate among various provider groups. The degree of discrimination is somewhat dependent upon the ability of the provider group to pressure the various administrative and legislative bodies to retain or protect traditional service areas.

Increased accessibility to services for all will be produced only if the acceptable levels of service are defined and provided at the lowest entry point in the system. For example, it would be most desirable to avoid forcing beneficiaries to be institutionalized where out-patient services can provide the required service. Out-patient service should be provided where the cost is most efficient; the same is true for in-patient services. The payment method must be designed so that those providers who can most efficiently provide acceptable access and service are encouraged to do so. The reverse is also true in that those who cannot efficiently provide the services within the acceptable criteria of cost must be allowed to suffer losses, or to drop out of the system.

The system may also recognize that it is socially desirable and acceptable to subsidize losses in some services in order to provide acceptable access. This, however, must be done in a manner that alerts the system, the patient, and the provider in advance of the required subsidy.

C. *The Encouragement of Orderly Growth*

Both the delivery and payment systems should encourage orderly growth and improvement of services without automatically providing subsidies for underutilized facilities and services. This could be accomplished for institutional services by tying a facility's costs to a given census level. Census levels can be pegged in a manner which will promote the orderly growth and replacement of obsolete facilities or services in the system.

Historically, health planners have used optimum census levels to assure that sufficient standby services are available to meet "peak" demands, but little attention has been given to the use of optimum census levels to encourage the orderly development of new facilities and services. This latter use of the census level will also create a competitive market environment in which beneficiaries may select health services which meet the quality standards.

The failure to use optimum levels in the present systems as incentives for orderly expansion has in effect franchised the present providers of service. There is no burden on them to increase their level of service or to add new services in order to compete for beneficiaries. It has also resulted in providers being able to avoid the intent of regulations simply because enforcing agencies have no alternatives for placement of patients.

D. *Incentives for the Patient to Seek the Cost Effective Provider*

For any system to ultimately function effectively, the patient must have some incentive to seek lower cost services. The entire system is predicated on the assumption that a socially acceptable quality of service has been determined and that all providers of a given service are required to meet those standards.

If each patient has a percentage participation in the cost of care, the patient will in turn become an effective instrument in containing those costs by seeking the best combination of service and cost. It must be recognized that the proper structure must be developed to insure that, in requiring this participation, the beneficiary is not barred from securing adequate services.

E. *The Rewarding of Efficiencies*

Health care is a service industry; therefore efficiency in the delivery of quality services is very much a function of the effectiveness of management. To attract and maintain effective management, a properly based system of rewards and penalties is essential. The most effective method is to permit providers to profit when they provide a quality service within the cost standards developed for providing that service. At the same time, the provider must absorb any losses incurred because of the failure to manage within the quality and cost standards.

F. *Administrative Simplicity*

Any system, in order for it to be responsive and viable, must be administratively simple. Many of the present payment systems function in a very cumbersome and expensive fashion.

They are generally very fragmented. The development of standards and regulations, the enforcement of those standards and regulations, and payment are often lodged in separate agencies. For example, the goal of the agency responsible for the payment system is cost containment, while the objective of the agency enforcing the standards is to increase those standards to assure the quality care. This often results in a natural conflict of objectives which is beyond the control of the patient or provider of services.

Consistent policies can only be achieved if a single agency has the overall responsibility and accountability for both the determination of acceptable levels of service as well as for monitoring and enforcing the budgetary restraints for all long-term care programs.

II—PRIMARY PRINCIPLES OF PAYMENT

The other major determinants in developing an effective system are the principles which are used as a base for the methodology of payment. There are many principles or conditions which may be applied to a payment system, but there are nine which must be present if the system is to be effective:

A. Rates & Charges Must Be Determined Prospectively.
B. Rates & Charges Must Be Cost Related.
C. A Profit Must Be Allowed.
D. The Payment System Must Encourage Cost Containment.
E. All Rates Must Be Related to Patient Assessment.
F. An Allowance for the Cost of Capital.
G. The Application of a Quality Assurance Penalty.
H. In Establishing Rates for Facilities, Standard Costs Must Be Used Relative to Their Socio-Economic Areas, Size, and Service.
I. The Availability of an Appeal Procedure.

Each of these principles is important by itself in assuring the effectiveness of the payment system but they are also interrelated in that the absence of any one of them would have a detrimental impact on the functions of the others. Briefly, the importance of each is based on several factors.

A. *Rates and Charges Must Be Determined Prospectively*

One of the inefficiencies of many of the present payment systems is that final determinations of payment are not made until long after the service is rendered to the patient. Frequently, the amount of final payment is more a result of the negotiating and accounting ability of management than it is of their health care administrative ability.

The retrospective cost reimbursement process also contains little incentive for management to expend any special effort to reduce or contain costs. This lack of concern for cost, has led to a myriad of regulations designed to cover what is a basic flaw in the system. This has without question resulted in uncontrolled increases of costs.

The provider has been effectively relieved of any responsibility for financial or budget planning since any plans have been adversely affected by extensive retroactive adjustments.

The prospective development of rates would allow management to know the amount of the payment as well as how it will be made in advance of the delivery of the service, thus creating considerable pressure for effective management. Also, under a prospective-rate system, the provider who is planning an expansion of services can more effectively review the feasibility of the expansion.

B. *Rates and Charges Must Be Cost Related*

The payment system must be related to the actual cost of providing quality health care services. A system which fails to relate payment to costs ends up penalizing the beneficiary, the provider, or the taxpayer. Underpayment results in a reduction of services or patients or in subsidizations by other patients, or an absorption of the loss by the provider. Overpayment results in inefficiency or an excessive profit. Properly relating payment to cost will result in each patient bearing an equitable portion of the costs. It will also provide a method whereby improvements in service can be readily implemented at a proper overall cost to the system.

C. *A Profit Must Be Allowed*

The opportunity for profit is absolutely essential to providers regardless of their organizational structure. Neither investor-owned nor not-for-profit providers can survive for long without a profit.

Profits provide the funds from which services are expanded; new jobs are created; future pension programs are funded; requirements are met for ever-increasing work capital (as distinct from physical asset capital requirements); entrepreneural risk is rewarded, and efficiency is both encouraged and enforced.

The acceptance of the principle of allowing a profit carries with it the antithesis of allowing a provider to sustain a loss. Any competent provider of health care services can and should be obligated to provide quality services in a cost effective manner.

Neither a profit nor a loss should be guaranteed by the patient or third party payer. The profit or loss should be the product of the provider's ability to provide quality care within the rate structure. A provider has a right to a profit opportunity, not a guaranteed profit.

D. *The Payment System Must Encourage Cost Containment*

Inflation in the health care industry has been a serious problem. The advent of Medicare and Medicaid service requirements together with retrospective cost reimbursement programs have resulted in staggering cost increases.

The public simply cannot afford any payment formula that does not contain incentives to control the cost of providing health services. Therefore, any future payment system must encourage efficiency and the containment of costs.

E. *All Rates Must Be Related to Patient Assessment*

Efficient and effective care for long-term care patients by its very nature dictates that the payment system be related to patient characteristics. Proper patient assessment will help to determine staffing patterns and services which in turn affect the rate structure.

The patient assessment should consist of comprehensive ratings of the physical characteristics, mental status, health status and other pertinent data for determining the level and intensity of care required by the patient. The aggregate assessment of all patients in the facility would then be used to establish standard care requirements. These care requirements would in turn be converted to standard nursing hours and costs.

The assessment system would assign points to the different types of care required by each patient for the purpose of determining the required level of care. It must be recognized that the initial classification of patients will require substantial commitments by the appropriate medical professionals. Sufficient initial lead time will be necessary to achieve a proper implementation of the program while ongoing monitoring will require limited commitments of both time and manpower. The data collected for the patient assessment must involve both the facility staff and the government agency under the control of appropriate health care professionals. The collection data must involve a minimum of time while being both comprehensive and easily understood by all persons needing to use it.

The patient assessment should be undertaken at the time the patient is admitted to the facility. The updating of each patient assessment would be made by the facility whenever significant changes in the patient's condition occurred, which then would be monitored by the proper agency and health care professionals. This process would be necessary to ensure not only that the change is necessary, but that any increase or decrease in care required by the change is actually provided to the patient.

The assessment is a tool to structure the payment rate to the patient's appropriate level of care while at the same time noting the changes in a patient's needs for a timely response to them. It would avoid, as much as possible, the traumatic effect of actual relocation when the patient's level of care changes.

F. *An Allowance for the Cost of Capital*

Capital resources of a firm, represented by owner or donor investment and by debt capital, provide the physical assets which are used as a base for services to long-term care patients. The standard payment rate for care of a facility's third-party payers' patients must include a return based on the adjusted replacement cost of the provider's assets. This is necessary in order to provide for interest, obsolescence and replacement of buildings and equipment. The determination of the cost of capital contemplates the assets being valued on an adjusted replacement cost basis.

This would eliminate inequitities among entities and pay a rate for fixed assets that is closely related to their actual worth. If the capacity to provide essential long-care services is to grow in an orderly and acceptable fashion for those who need to use it, an acceptable method of allowing for replacement of assets must be established. This point is recognized in the study entitled "Profit and Growth Allowances for Owner/Operator Contributions in a Cost-Related Prospective Payment for Services System for Nursing Home Care" (Health Care Center, Human Affairs Research Centers, Battelle Memorial Institute, December 15, 1974). The study strongly advocates the use of price level depreciation to ensure the orderly and efficient growth of the industry.

A method of depreciation based on adjusted replacement cost is necessary since, in current economic situations, conventional depreciation does not provide sufficient funding to replace physical assets of facilities as they wear out.

G. *The Application of a Quality Assurance Penalty*

A payment system for long-term care should reward those who effectively provide quality care and penalize those who are not efficient or do not provide an acceptable level of service. When a provider of health care services accepts third-party patients, the management has agreed to accept the responsibility for providing quality care at a standard rate. Therefore, to assure the agreed quality is maintained, it is necessary to audit the services rendered and impose penalties when the facility fails to maintain the quality standard.

A meaningful penalty must also be available for the governmental agency to impose on any provider when established quality standards are not being met. In most cases, when inspections reveal deficiencies, the responsible agency reports the deficiencies to the facility; the facility must then submit its plans for correcting the deficiencies. After 30 days, the agency will usually reinspect the facility to determine if the facility is in compliance.

It is recommended that when facilities fail to meet standards after 30 days, or when they continually fall into non-compliance, the responsible agency be authorized to withhold its payments to the provider until the quality standards are met. This would be subject to administrative review procedures to avoid arbitrary and capricious use of this authority.

The penalties themselves must be related to the provider of the services. This will require thoughtful development to ensure that such penalties or sanctions are not in turn passed on to the patients. Otherwise, the ultimate victim would be the patient for whom the effort was being made to improve the services.

H. *In Establishing Rates for Facilities, Standard Cost Must Be Used Relative to Their Socio-Economic Areas, Size and Service.*

To encourage and reward management efficiency, rates should be based on standard costs of rendering varying degrees of care and services. As an assurance that standards shall be equitably determined, costs of care and services should be related to socio-economic areas, size of facilities, and type of service rendered. Standard costs within the various groupings could be based on historical statistics and financial data modified by government regulations and inflationary factors.

Grouping facilities for payment by socio-economic areas, size, and levels of patient care will distinguish the different types of facilities. For example, costs of patient care will vary according to the facility's socio-economic characteristics (e.g., labor costs tend to be higher in urban than in the rural areas) as will the patient costs in larger facilities in comparison to smaller ones. If facilities were not classified into groups, some would be penalized for circumstances beyond their control. The small rural facilities, for example, could be penalized solely because of their location. This would be unfair because many areas in a geographic location cannot support a large facilit due to equipment and staffing requirements. The patient care costs of facilities for different levels of care will also vary.

Therefore, to make facilities comparable for standard cost purposes, they must be grouped by socio-economic areas, size, and service.

I. *The Availability of an Appeal Procedure*

A formalized appeal procedure must be established within each state using uniform administrative procedures. An aggrieved party would be allowed to appeal any act in cases where the provider, patient or third party payer feels equity has not been obtained.

Appeals could be made in special rate determination matters, in the quality assurance area, or in any administrative area. After exhausting administrative remedies, judicial review should be allowed patients, third party payers, or providers who consider the results of administrative review inadequate.

III—METHODOLOGY OF PAYMENT

The methodology of a payment system is without question the most important part to all concerned, including the patients, the third party payers, the pr viders, and the taxpayers. It is the determinant of the quality, amount, and cost of services which are provided to the patient.

The fundamental principle of an effective methodology is the same as that of the payment system itself: to promote quality care at a reasonable cost. In addition, the methodology is an integration of the other "Common Objectives" and the other "Primary Principles of Payment" into a responsive and manageable system. Based on that integration, the methodology would be composed of the following elements:

- A. Service Cost Components
  - 1. Standard Services
  - 2. Capital
  - 3. Patient Services
  - 4. Ancillary Services
- B. Profit
- C. Administration
  - 1. Rate Determination Process
  - 2. Effective Period of Rate
  - 3. Public Disclosure
  - 4. Appeal Process

Each of these elements has a key role in assuring the effectiveness of the methodology of payment as well as the entire health delivery system.

A. *Service Cost Components*

1. Standard Services

Standard services are those services common to all facilities, whose cost for a given level of service would not vary significantly, except for the size of the facility or geographic location. Standard services would include such sub-components as:

(a) Administration
(b) Dietary (Standard)
(c) Housekeeping
(d) Laundry and Linen
(e) Maintenance of Buildings and Grounds
(f) Medical Records
(g) Training
(h) Medical Director
(i) Utilization Review

The cost for these standard services would be developed by using a standard cost methodology.

The amount allowable for standard services would be a calculated flat per diem amount. This would be accomplished by grouping facilities by size, type and socio-economic location. In each service category, objective techniques can be developed and applied to determine a reasonable cost of providing services which meet predetermined standards. Historical costs systematically collected in a standard reporting format would be one factor used in the determination process, but they would not be the only one.

Changes in service standards, which have been and should remain fluid, must be considered when determining the cost. Also, the inflation of wages and the cost of products purchased by the facility must be considered when computing the standard cost used to determine the payment. Included in the payment mechanism is the assumption that the standard costs will be developed using predetermined occupancy levels. It is recommended that the occupancy level be set at 85%.

The levels at which utilization is pegged must:

- Recognize the function of utilization in encouraging growth;
- Insure the third-party payer from bearing the burden of under-utilized facilities and services
- Not discourage growth by pegging occupancy levels artificially high or low.

2. Capital

The capital that must be attracted to the industry comes from three sources:

- Federal, state, or local government
- Social, religious, or charitable organizations
- Private individuals and organizations.

Since none of the three sources has infinite funds to finance all possible projects, the nursing home industry must compete for funds with the other investment opportunities. Because the investors (whether government or individual) have alternative opportunities for investment, the payment received for invested capital must be considered a cost, for as capital is used, it must be replaced. If capital is not replaced, then the project it originally finances will be liquidated over a period of time. The payment for capital costs, whether the capital is owned or leased, consists of two factors: 1) An interest rate equal to the current mortgage interest rate (to compensate for the use of capital), and 2) A depreciation factor based on the current replacement value of the capital assets.

The method to be used to determine the payment for capital costs is the current replacement cost of a new facility adjusted for the age of the existing facility. This is a compromise between using the actual replacement value of the facility and its book value.

A payment for capital based only on book value would provide little incentive to keep fully or highly depreciated beds available when a higher payment could be received on new beds. The converse is true with a replacement value system as there would be little reason to open new beds when old beds could receive a payment based on current replacement value.

However, an adjusted replacement cost formula, as outlined below, would produce a capital payment somewhere between the book value and current replacement value of a facility. Thus, both the third-party payer and the facility benefit from this system.

This system would also encourage older facilities to remain in operation throughout their economic life, while reducing the cost to the third-party payer. At the same time, it would insure an equitable payment for new facilities.

The formula for computing the adjusted replacement cost base would be:

$$\text{Replacement Cost Base} = R\left[1 - \sum_{i=1}^{A} d_i\right]$$

Where A = Age in years of existing facility.

d_i = A depreciation factor during each existing year of the facility of .03 or one-half the change in the consumer price index (CPI), whichever is less.

R = Value of a hypothetical model facility within the geographical area. This value would be 125% of the value determined for the building, assuming that land represents 10% of building and equipment 15% of building.

For example, if current per-bed building costs in a given area are $10,000, the cost of a hypothetical model facility per bed would be $12,500, assuming land and equipment to be 25% of the building cost (125% × $10,000).

Thus, the $45,000 allowance is 3.6% of the adjusted current replacement value of $1,250,000, and represents a case where ⅔ of the depreciation is on the building and ⅓ is on the equipment.

Therefore, 3.6% would be applied, together with an interest factor, to the adjusted replacement cost for establishing the capital allowance per diem for property costs.

The interest factor would be added to the depreciation percentage to arrive at the total per cent payment on the adjusted replacement cost. The interest rate used would be calculated on a representative sample of nursing home mortgage loans over the most recent six months for the applicable rate period.

If the payment for capital consists of 3.6% for depreciation and 9.5% for the current interest value, the payment would be 13.1% of the replacement cost base. For example, if the cost of a new 100-bed facility is $10,000 per bed ($1,000,000 cost), the total adjusted replacement cost, including land and equipment, would be $1,250,000. The adjusted replacement cost basis for the above-noted 100-bed facility at various ages, together with the capital allowance, is shown in the following table.

Age of Facility in Years	*Adjusted Replacement Cost Basis*	*Capital Payment (at 13.1%)*
0	$1,250,000	$163,750
5	1,093,750	143,281
10	937,500	122,812
15	781,250	102,344
20	625,000	81,875
25	468,750	61,406
30	375,000	49,125
35	375,000	49,125

The formula applied to a 10-year-old facility in which the CPI increased 6½% a year for five years and 4% a year for five years would be as follows:

$$\begin{aligned}\text{Replacement Cost Base} &= \$12{,}500 \times \{1 - [.03\,(5) + .02\,(5)]\}\\ &= \$12{,}500 \times [1 - .25]\\ &= \$\ 9{,}375.\end{aligned}$$

Thus, the capital allowance for a 10-year-old facility would be calculated on a replacement cost of $9,375 per bed.

Substantial benefits will accrue to the entire system from the participation of older well-run facilities. It is recommended, therefore, that a minimum or "floor" be established at 30% of the current replacement value. A significant advantage in this approach is that changes in the ownership of a facility do not affect a facility's replacement cost. Regardless of the sale price and the new-owner book values, under this concept, the basic value of the assets in the rate determination would remain a function of the formula.

To simplify the computation of the allowable depreciation, a percentage rate is developed based on a weighted composite rate for a model facility. This allows for a flat percentage to be applied against the adjusted current replacement cost of all participating facilities.

Model Facility Built in 1975

			Depreciation		*Component*	
	Cost	*Life*	*Rate*	*$*	*Relationship*	*Composite*
Land	100,000	—	—	—	—	—
Building	1,000,000	33 years	3%	30,000	0.667	2.4%
Equipment	150,000	10 years	10%	15,000	0.333	1.2%
TOTAL	1,250,000			45,000	1.000	3.6%

The total capital payment is now divided by the applicable census days to determine the per diem cost to be included in the rate. If 85% occupancy level is used in this calculation, the applicable census days for a 100-bed facility to be used in this calculation would be; 100 beds × 365 days × 85% = 31,025. Thus, the per-diem capital allowance for a new 100-bed facility (in the above table) would be $163,750 ÷ 31,025 = 5.28; for a 15 year-old facility, $102,344 ÷ 31,025 = 3.30; and, for a 30-year-old facility, $49,125 ÷ 31,025 = $1.58

3. Patient Services

Patient services are those services the cost of which varies with: 1) the number and skills of personnel; 2) specialized equipment; 3) physical arrangement of the facility; and, 4) most importantly the specific needs of those patients admitted for care. Patient services would include:

a) Nursing services, including restorative nursing
b) Activities
c) Social services
d) Special disability services (mentally disordered and developmentally disabled)

The patient services outlined above are generally accepted to be unique to the individual patient's needs.

Payment for these services would be a product of the aggregate need of the patient translated into hours of labor and then into dollars using a standard labor rate.

4. Ancillary Services

Ancillary services are those services which are not routine in nature and require a physician's order. Such services do not lend themselves to the "averaging" process used for standard services.

The needs of nursing home patients are such that while all patients require certain minimum patient services, individual patients require unique ancillary services both as to quantity and type.

Those items commonly recognized as ancillary services include:

a) Pharmaceutical services
b) Restorative therapies
    i) Physical
    ii) Speech
    iii) Audiological services
    iv) Inhalation therapy

The payment for ancillary services must be developed in a manner similar to all services in that each ancillary service will have a standard cost including an opportunity for profit or loss.

There are two primary reasons for separating these costs from patient care costs: 1) Not all patients require these services; therefore, those patients who do require them should pay the entire cost of the services rather than sharing it with other patients. 2) The management of these services is more complex; hence, the management expense should not be included in the cost of standard services but should be borne exclusively by the beneficiary of such a service.

B. *Profit* or *Loss*

The opportunity for a profit or loss is an essential component of a workable and efficient payment system. This point is often overlooked, but to do so is to ignore the fact that the provision of institutional long-term care services is both a service and a capital intensive business.

Substantial capital commitments on what is basically a one-time basis must be made, but it generally represents less than 25% of the operating cost of most facilities. The remaining 75% of the cost is a "service" cost, composed primarily of labor costs which are very sensitive to managerial skills and effectiveness.

The cost of capital, therefore, cannot be considered as the profit factor for institutional providers because, while it provides the facility, it does not provide the services. The profit opportunity should be a fixed amount for all facilities which is related to the 75% service portion of daily costs, as well as the 25% cost of capital. The fixed allowance should be based on an equitable percentage of the aggregate pre-tax standard costs in a given service area. In normal operating circumstances, this would mean that any profits would be shared between the provider and the Federal and state governments since profits are subject to income taxes.

To develop an "equitable percentage" for the profit opportunity it is necessary to have a system for comparison measurement of profits. Based on the fact that approximately 75% of the industry's costs are service costs, the profit potential of the health care industry should be similar to that of other service industries. This is important because if the return in this industry is less than the return in equivalent industries, capital and investors (and, hence, quality) will disappear. The end result will be a scarcity of adequate long-term care services in many areas of the country.

The DuPont Chemical Company, whose products vary in terms of their intensity of labor and capital costs, developed a procedure called the "DuPont ROI Method" in order to compare the profitability of its products and thereby determine an accurate measure of its total return on investment.* This method ex-

---

**ROI—Return on Investment*

amines the return of total investment by multiplying the profit margin by the asset turnover:

$$\text{ROI} = \frac{\text{Earnings Before Interest \& Taxes}}{\text{Sales}} \times \frac{\text{Sales}}{\text{Assets}}$$

or

$$\text{ROI} = \text{Profit Margin} \times \text{Asset Turnover}$$

For example, if the pre-tax and pre-interest profit margin of a product is 10% of revenues, and the sales of the company are twice as much as the assets of the company, then the return on total investment will be:

$$.10 \times 2 = .20 \text{ or } 20\%$$

However, if the sales are the same as assets (turnover = 1), the return on total investment is:

$$.10 \times 1 = .10 \text{ or } 10\%$$

In other words, the return on investment is affected by changes in profit margins or changes in sales in relation to a fixed amount of assets. Therefore, if the asset turnover is low (as in the nursing home industry), the profit margin must be higher in order to receive the same return.

In the above case, if the sales equaled assets, there would need to be a 20% profit margin in order to have the same 20% return on investment as in the first example:

$$.20 \times 1 = .20 \text{ or } 20\%$$

Thus, by finding the return on total investment for service industries comparable to the nursing home industry, and by knowing the asset turnover of the industry, it is possible to determine the profit margin that should be allowed.

A survey by *Standard and Poor's* of its 425 industrials indicates that the average pre-tax profit margin from 1967 to 1973 was 15.5%. When this is broken down into four major service industries (Air Transport, Hospital Supply, Radio and TV, and Trucking), the average profit margin becomes 13.9%. The profit margin, however, is only part of the return on investment received by these industries.

The pre-tax profit margin between service industries is not comparable due to the amount of leverage (or debt) that exists in these industries and the differences in asset turnover. In order to compensate for the leverage between industries, the proper profit margin should be:

$$\frac{\text{Profit Before Interest and Taxes (On Income)}}{\text{Sales}}$$

The pre-tax and pre-interest profit margin for the four service industries is 15.1%. Once the proper margin is defined, the differences in asset turnover can be taken into consideration.

The average asset turnover for the service industries noted above from 1964 to 1973 was 1.30. Therefore, the average return on investment before intere and income tax for these industries is calculated to be 19.6%. This is computed from the DuPont ROI Method as follows:

ROI = Asset Turnover × Profit Margin (Pre-Interest & Pre-Tax)
= 1.3 × .151
= .196 (or 19.6%)

The numbers used are the average asset in the service industry turnover and the average profit margin.

Because the health care industry is both labor and capital intensive, it is reasonable to consider both the capital costs and a profit opportunity on service for the industry. Given the average long-run capital costs in the industry are around 9.5% (the present average borrowing rate for mortgage money), and that the asset turnover in the industry will be approximately 90% (based on a study of multi-facility nursing home firms), with the adoption of this program, a pre-tax profit margin of 11.2% on revenues (12.47% on costs) would allow this industry to receive a return on investment roughly equivalent to that received by other service industries (including those whose rates are controlled).

This conclusion is developed from the following analysis. If the average return on total investment for all service industries is 19.6%, then an opportunity for similar returns in long-term industry is justified. Thus, when applying the DuPont ROI Method, the ending return should be 19.6% The formula for health care industry consists of several factors besides asset turnover. The facility receives a pre-tax and pre-interest profit margin from two sources. The first source is from the interest portion of the capital payment and the second is from the profit margin on services.

If the asset turnover is .9 and the interest rate is .095, then the interest part of the capital payment in relation to sales is .095/.900 or .1056. For example, under the above circumstances a facility with $1,000,000 in total assets would have sales of $900,000. The capital payment at 9.5% would be $95,000 (.095 × $1,000,000). This represents a pre-tax and pre-interest profit margin of .1056 ($95,000/ $9000,000).

The remaining profit margin on services, when added to the interest portion of the capital payment and multiplied by the asset turnover, should equal the desired 19.6% return. Thus, with a .9 asset turnover and the .1056 margin from the interest payment, a profit margin on services of 11.2% (.112) is required in order to attain a total return of investment of 19.6%.

The computation of return on investment is:

$$\text{Return on Investment} = \text{Asset Turnover} \times \left[\text{Pre-Tax \& Interest Profit Margin}\right]$$

$$\text{ROI} = \text{Asset Turnover} \times \left[\text{Pre-Tax Margin On Revenues} + \frac{\text{Interest Payment On Capital Cost}}{\text{Asset Turnover}}\right]$$

$$.196 = (.9) \times \left[\text{Pre-Tax Margin On Revenues} + \frac{0.95}{.900}\right]$$

$$\text{Pre-Tax Margin on Revenues} = \frac{.196 - .095}{.900}$$

$$= .112 \text{ or } 11.2\%$$

It should be noted that the total pre-tax and pre-interest profit margin for nursing centers, as outlined in this paper, is 21.76% (10.56% from the capital payment and 11.2% from the service). While the profit margin is greater than the 15.1% from other service industries, it is entirely justified because of the lower asset turnover in the nursing home industry, 1.30 for the former as opposed .90 for the latter. Historically, firms with low asset turnovers have generally had higher profit margins and the higher profit margins are needed to equalize the return on total investments. With this profit opportunity on revenues, the industry will have an opportunity to earn a fair, but not excessive, return.

C. *Administration*

The administration of the payment methodology must be the responsibility of the same agency who is also accountable for determining the acceptable levels of service. This will greatly facilitate the expeditious determining of the rate.

1. Rate Determination Process

All rates are to be established on a prospective basis according to standard guidelines developed in accordance with the preceding "Cost and Profit" components. Facilities would, therefore, be grouped by their socio-economic areas, their size, and the services they provide.

Standard costs can be developed within each of these groups to represent what the amount should be for each component, with the exception of the cost of capital. The data necessary to accomplish this objective can be obtained through three forms: 1) a cost statement; 2) a budget for the period of the rate; and 3) a report on the assessment of patient needs. Each facility would then be paid this prospective standard rate based on a predetermined occupancy level (see page 5). The payment allowed for the cost of capital of each facility can then be added to arrive at a total routine per-patient per-day rate.

Ancillary services would be subject to standard costing and would be charged on a per unit of service as consumed by the individual patient. For example, a given modality of physical therapy might be determined to have a standard cost of $5.50 to which a permissible profit opportunity percentage would be added.

This specific service would then have a price of $6.19 (the 6.19 is a result of the cost + profit or $5.50 + profit (12.61 × 5.50) or .69. The gross margin will be .69, or 11.2% of the unit of service price.

2. Effective Period of Rate

Rates should be established prospectively for a twelve-month period, preferably to coincide with agency fiscal budgetary periods. If rates were established on a fiscal-year basis, the data accumulation period would probably have to be ended some six months earlier (December 31) to permit timely submission and evaluation of historical data.

Changes in the prospective rate during the year should only be allowed for changes in minimum wage laws and other changes in rules or regulations which affect the cost structures of facilities.

3. Public Disclosure

For the purpose of setting rates, each facility should be required annually to disclose its applicable costs, subject to a timely audit by a rate-setting agency. However, audits should be done on an exception basis rather than requiring every facility to undergo a certified audit each year.

Failure to disclose costs might lead to exclusion from the program. Submission of late financial reports can be subject to administrative penalties to be established by both the industry and the government agency.

4. Appeal Process

Final administrative decisions in the rate-determination process shall be subject to administrative and judicial appeal. The responsible agency shall establish a maximum period (not less than 30 days) for a provider or patient to notify it, in writing, of any intent to appeal a determination or decision. Following the exhaustion of administrative remedies, either party may request judicial review.

IV HYPOTHETICAL EXAMPLE

A hypothetical daily routine service payment would consist of four components (amounts for example purposes only):

I.	Standard Service (SS)	= Developed on a standard cost basis for a group of facilities	=	6.45
II.	Patient Service (PS)	= Developed on the aggregate needs of the facility's patients	=	9.67
Service Allowance subject to profit calculation			=	16.12
III.	Profit Opportunity	= 12.47% of the combined standard and patient services costs (see page 14)		
		= 12.47% (PS + SS) 12.47% (6.45 + 9.67) 12.47% × 16.12	=	2.01
Service Allowance plus profit opportunity			=	18.13

NOTE: 11.2% of $18.13 equals $2.02 or the profit allowance on revenues as derived from the above computations of costs. (see page 14)

IV.	Capital Allowance (C) (see page 13)		=	5.28
	Total daily routine service rate		=	$23.41

Thus, in formula the total routine daily service rate, (T.R.R.) is as follows:

TRR = SS + PS + P + C
= 6.45 + 9.67 + [.1261 (6.45 + 9.67)] + 5.28
= 16.12 + (.1261 × 16.12) + 5.28
= 16.12 + 2.01 + 5.28
= 23.41

STATEMENT OF JACK A. MACDONALD ON BEHALF OF THE NATIONAL COUNCIL OF HEALTH CARE SERVICES, BEFORE THE SUBCOMMITTEE ON HEALTH OF THE SENATE COMMITTEE ON FINANCE, JULY 30, 1976, ON THE SUBJECT OF S. 3205

Mr. Chairman, members of the Subcommittee, my name is Jack A. MacDonald. I am the Executive Vice President of the National Council of Health Care Services, which represents a select group of proprietary multi-facility nursing home firms. Members of the National Council own and/or administer more than 75,000 beds in long term care facilities throughout the country. Members of the Council also are involved in other health related services such as hospitals, psychiatric, rehabilitation and day care centers.

We appreciate this opportunity to appear before you today, and submit a brief statement concerning S. 3205.

First, we would like to commend the Chairman for taking the initiative reflected in his bill to correct, and hopefully, reform the Medicare and Medicaid programs. We strongly support the intent of S. 3205 as reflected in the title of the bill "Medicare—Medicaid Administrative and Reimbursement Reform Act". That title effectively delineates the two areas which are the cause of the major problems of the Medicare and Medicaid programs. Solutions to the problems in those two areas must be found before the adoption of any national health insurance program. If we do not solve those problems now, they will be magnified tenfold under a national health insurance program.

Mr. Chairman, your efforts and those of your colleagues are vitally important in the meeting of that need.

I. INTRODUCTION

The present diffusion and confusion in the administration of the Medicare and Medicaid programs has created a regulatory quagmire which has prevented the effective operation of the two programs. It has also created problems in the enforcement of standards which in many instances have led to the abuses noted by various critics of the health industry. These problems involve eligibility criteria for beneficiaries, the delivery of services, certification of providers, and payment for services rendered under the programs.

A more effective administration is required if this situation is to be corrected. This can only result, however, if a single authority has the overall responsibility and accountability for (1) determining the acceptable scope and levels of services and (2) monitoring and assuring that the budgetary constraints are met for services rendered to beneficiaries. The present administrative formats of the Medicaid program and the Medicare program have been costly and ultimately detrimental to the provision of quality health care at a reasonable cost.

Though one might argue that Medicaid is significantly different from Medicare because it is administered by the States, nevertheless, the States are administering the Medicaid program under federally mandated regulations. These regulations presently leave the States with little flexibility once they have determined the beneficiary's eligibility and need for services under the Medicaid program. For these reasons, the proposed consolidation and restructuring of the responsible Federal agencies under a single authority, the Assistant Secretary for Health Care Financing, as set forth in S. 3205, would greatly assist in resolving the confusion in the administration of the Medicare and Medicaid programs.

While there is a strong need to restructure the administration and the payment systems of the two programs, there is also a counter-balancing need to stabilize the Medicare and Medicaid standards for beneficiaries and providers. In this area, the changes made as a result of the Social Security Amendments of 1972, P.L. 92–603, need to be examined and evaluated as to their impact before any new major revisions are made involving the skilled nursing and intermediate care facilities under the two programs. An exception might be made for the amendments clarifying or correcting unintended or undesirable results. Maintaining stability in standards is as important as consolidating and restructuring the administration and payment systems of the two programs. Mr. Chairman, this may be achieved under the format proposed by S. 3205.

Based on that philosophy, we offer the following comments and recommendations concerning the specific sections of S. 3205.

II. SPECIFIC COMMENTS

A. Section 2

We support the proposed consolidation of agencies, as well as the administrative and policy responsibilities set forth by this section. As noted earlier, an effective administration of the Federal Government's participation in the Medicare and Medicaid programs can only evolve if a single agency has the overall responsibility and authority to administer the programs. Anything less is both duplicative and cumbersome.

B. Section 10

It is our understanding that this section, as proposed in S. 3205, only pertains to hospitals. It would require, however, the Secretary of HEW to "develop" and report to Congress within three years, recommendations for "comparable reimbursement methods" for any or all other providers, including "skilled nursing and intermediate care facilities".

We are concerned that this might preclude the use of Medicaid payment developed by States pursuant to Section 249 of P.L. 92–603. The regulations implementing Section 249 were just published July 1, 1976, and will not be effective until January 1, 1978, even though the statutory provision clearly states an effective date of July 1, 1976. Regardless, we would anticipate a number of new payment systems will be developed under this provision, which should not be encumbered by the system outlined in Section 10 of S. 3205.

It is our suggestion that the Secretary should be strongly encouraged to utilize Section 249 as a means to develop "improved methods" for establishing prospective payment systems for nursing home services for both the Medicaid and Medicare programs.

C. Section 11

Mr. Chairman, we would acknowledge the fact that there may be, at the present time, an excess of hospital beds in some parts of the country. However, we are concerned with the possible results of this section of S. 3205.

It should be noted that the shifting of excess hospital beds to another purpose could easily result in an excess of beds in the latter area. At the same time, it might be necessary at a later date to switch the hospital beds back to their original purpose, which could result in a shortage in the alternative service area.

We would also point out that there is a difference in physical plant standards between hospitals and nursing homes. Nursing facilities are now being required to have more available floor space than for hospital patients outside, as well as inside, their rooms, for what the regulations define as general "activities of daily living".

We would suggest that any facilities being converted from hospital usage to that of a nursing home should have to meet the same standards as are required of facilities originally constructed and developed as nursing homes. To do otherwise would be to discriminate against those facilities built for the purpose of nursing facilities.

It is, therefore, our recommendation that the Sub-Committee should carefully weigh and consider the possible ramifications of the conversion of excess hospital beds on other segments of the industry. To put it simply, we are concerned that the medicine might be worse than the disease.

D. Section 12

This section would increase a proprietary facility's rate of return, which it is allowed under the Medicare program, on its net capita lequity. In the context of the present Medicare payment system, we would, of course, favor this change since we do not feel Medicare's current rate of return, after taxes, is competitive with that of other service industries.

In general, however, we oppose the use of equity as the only basis for a profit or a growth factor under Medicare. Equity based returns in the health industry, we feel, tend to provide few positive incentives for efficiency or the delivery of high quality services. In fact, the reliance on the equity standard has encouraged a number of abuses in the area of real estate transactions and their invested capital. This industry, as a whole, tends to be labor intensive as opposed to most other industries which utilize an equity based return are usually capital intensive.

We, therefore, would recommend that the Sub-Committee give consideration to allowing experimentation with a factor for profit or growth under the Medicare program, on a basis other than solely on an owner's net equity. The opportunity for this, we feel, exists at the current time under the Medicaid program, as provided for under Sub-Section E of Section 249 in P.L. 92–603.

E. Section 30

This section would insert a parenthetical phrase clarifying the intent to allow State Medicaid agencies the discretionary authority to include a "reasonable profit" in cost related payment systems and rates, developed pursuant to Section 249 of P. L. 92–603. The original statutory language of Section 249, along with the Senate Finance Committee's Report on P.L. 92–603, as well as the items which you raised recently, Mr. Chairman, wiht the Secretary of HEW, F. David Mathews, regarding the proposed regulations, leaves little doubt that States were intended to already have that type of discretionary authority in the development of their State Medicaid payment systems.

This viewpoint was reflected in the final regulations, issued by the Department of Health, Education and Welfare implementing Section 249. The regulatory language neither prohibits nor requires that a State include in its rate a profit or a growth factor.

The Preamble to the final regulations, however, has confused the issue somewhat. On the one hand, it specifically recognized the need for a profit for proprietary facilities, while at the same time tending to limit the flexibility of States to have a return other than one based on net capital equity. The Preamble to the regulations, however, also speaks favorably of a payment system developed by a State which provides for a return based on items other than solely the owner's net equity.

We would suggest that the Sub-Committee might wish to consider availing itself of the opportunity to clarify this issue in this section of S. 3205. This could be accomplished by allowing a State the specific option to design and determine for itself not only the amount of profit or growth opportunity, but also the method of determining that factor under its payment system.

This would also provide the opportunity to develop and ultimately reform the payment system for services under both the Medicare and Medicaid programs. This, we feel, would provide a method for correcting the apparent failure of the Social Security Administration to develop new and innovative payment systems for nursing homes under Section 222 of P.L. 92–603. Hopefully, it would also facilitate the development of a solution to the problems outlined in our comments on Section 12.

F. Section 31

This section would establish the Secretary as the certifying authority for skilled nursing facilities. Presently, skilled nursing facilities participating in the Medicare and Medicaid programs are certified by a State survey team on the basis of Federal regulations. However, present regulations require that the survey findings be reviewed by the various responsible Federal agencies in the HEW regional offices.

It is our opinion that the problem in the area of certification and enforcement of standards is not one of who should be certifying, inspecting, and enforcing, but rather one of unifying the standards and surveys under a single authority. There is presently no authority empowered to say yes or no on a timely basis in response to a certification finding.

It should be noted that skilled nursing facilities participating under the Medicare and Medicaid programs are at the present, subject to more than 520 detailed Federal requirements. These standards are surveyed and reviewed by different authorities, including, in some instances, duplicate Federal and State survey teams reviewing a facility's compliance with the same standard. As we have stated, there is a clear need to unify the certification process under a single authority, and we strongly support any attempt to accomplish this task.

Another related issue is the need to distinguish between those facilities which, as a result of the certification surveys, are found to present an immediate and serious threat to the safety and health of the patients and those facilities with lesser violations of health care. In the former situation, there might appropriately be a basis for the temporary take-over of the facility, pending a hearing by a Federal court, by a trustee.

In the latter instance, there ought to be an immediate hearing with a specified maximum period set during which time payment continues to the facility, subject, to the results of the hearing.

If the Federal Government assumes the role of the final certifying authority for both programs then the hearing procedure would also become a Federal function, and should be delineated as a part of Section 31. If the States continue to retain the certification authority for the Medicaid only provider, then we would also suggest that the States be required to provide a fair hearing on the basis that they are applying and administering Federal standards.

We would also recommend that the certification procedure and authority for the intermediate care facilities be the same as that used for skilled nursing facilities. This is necessary, we feel, since many skilled nursing facilities are also intermediate care facilities under the Medicaid program. Any other arrangement would not be administratively sound or in concert with the expressed intent to consolidate the policies and administrative authority for the two programs.

G. Section 32

This section would require the use of Medicare's tests in determining the reasonable value of facilities bought, sold, or leased for purposes of payment under the Medicaid program. We would readily acknowledge the problems which have been brought to light as a result of the manipulation of property costs in certain situations, however, we are concerned that these problems will not be resolved by the simple application of Medicare standards.

We would point out that the emphasis on real property, capital, and equity, in the calculation of payment rates under the Medicare program is an inherent weakness of that payment system. We would urge that the Sub-Committee give thought to allowing and encouraging the States to develop payment systems which de-emphasize an individual owner's equity standing in the calculation of a fair and reasonable profit or growth factor.

The sale of assets should not be a key determinant of a facility's profit or growth factor. There are several methods which could be used under Medicare and Medicaid, which would de-emphasize the need to recalculate the value of a property after a sale.

H. Section 40

Generally, we are somewhat concerned with some of the provisions in this section which would retrospectively restrict individual operational cost items. We would hope to have more emphasis on the competitiveness of aggregate rates in relation to a given quality level of service as a result of prospective payment systems.

This section specifically concerns us in regard to the following four provisions:

1. Overhead Costs

HEW would be directed to limit payment for overhead costs by taking "appropriate account" of the relationship between overhead and direct service costs. This is a burdensome involvement in a provider's day to day operational management, under a standard so vague as to give HEW almost total discretion. If better services can be provided by spending more on management and less on direct labor, for example, the facility's administrator should be free to make that choice.

The concern should be with the competitiveness of the aggregate rate, not with the manner in which a provider allocates his operational costs.

2. Leases

Leases based on a percentage of service costs would be prohibited. While there has been abuse in this area, it too has been primarily between related parties. Where the lessor and lessee are at arm's length, percentage leases, if determined in the aggregate to be competitive, should be allowed as a proper method to apportion risk and reward effective management. Leases of this type are standard in other business settings and we question whether they should be prohibited here.

3. Consolidated Cost Reports

Consolidated cost reports would be required from provider firms. The language as now drafted appears to be extremely broad and vague as to what will constitute a "consolidated cost report". The term "consolidated cost report" from the standpoint of an entire corporation, could include those substantial dealings of the corporation which have no involvement in health care or government programs. The preparation of a cost report on that basis might be an accounting nightmare going far beyond the data needs of either the Medicare or the Medicaid agencies.

We would recommend a clarification in S. 3205 or the Sub-Committee's Report to take into account this potential problem by referencing the appropriate specific criteria from generally accepted accounting principles or the Cost or Financial Accounting Standards Boards.

4. Advance Approval of Contracts

We would respectfully submit that advance approval of all contracts in excess of $10,000 as proposed in this section, presents numerous administrative problems. First, the dollar amount is so low as to be almost totally inclusive of all operational contracts. This would entail greatly increased involvement by the Government in the day to day administrative decisions of a provider. It would severely tax the ability of either States or fiscal intermediaries to process approvals on a timely basis.

Second, the standards for approval of contracts are in our opinion too vague; i.e., that the service be "appropriate", that the contractor be "qualified", and that the price be "reasonable". This leaves too much discretion to the administering agencies, and would necessitate the development of extensively detailed regulations. Even with detailed regulations, however, their uniform application among intermediaries and State agencies would be extremely difficult.

The inevitable effect would be to discourage the use of all contract services and require increased capitalization of providers. This will in turn result in fewer providers and less competition in the industry, not to mention possibly increasing the cost of services. This would be unfortunate for the beneficiary, taxpayer, and provider, in that many operational services can be provided more efficiently and at a lower cost on a contractual basis, than by the individual provider.

The abuses in the area of contracted services have again involved related party transactions. This has ultimately been a problem of disclosure and enforcement. The Senate Finance Committee's amendments to the Social Security Act of 1972 provided the means to resolve this situation, but they have not been implemented and enforced in a timely manner.

Where a genuine arm's length relationship does exist, we see no need for the amount of constraint proposed by this section, especially for services of a general operational nature. Where there is an absence of a genuine arm's length relationship, we suggest the application of a standard based on a comparison to market price, rather than a reasonableness" standard. In addition, the final regulations implementing Section 249 of P.L. 92-603 already require disclosure of related party transactions and cost determination on the basis of the lower of actual cost or market price.

III. ADDITIONAL RECOMMENDATIONS

A. Jurisdiction Over the Sale or Purchase of an Existing Facility

We would like to take this opportunity to call to the attention of the Sub-Committee the problems created by the interpretation and resulting regulations implementing Section 221 of P.L. 92-603. The Department of Health, Education, and Welfare issued regulations (42 CFR 100.103(a)(1)) on November 9, 1973, which require that the purchaser of an existing facility must obtain approval for that purchase from the appropriate comprehensive health planning agency.

This is beginning to present a severe problem and hardship for both the seller and purchaser of health facilities.

In the case of Herbert L. Rogers vs. F. David Mathews, Secretary of HEW, the Department has acknowledged in its brief that they inserted the word "or" in the regulation between the statutory phrase "(i) exceeds $100,000" and "(ii) changes the bed capacity of a facility with respect to which such expenditure is made". On the basis of that insertion, the Department of Health, Education and Welfare is attempting to exercise jurisdiction over the sale of existing facilities. This has resulted in some instances, in the purchaser having a hardship in obtaining financing for the facility because of the fact that it is unknown whether or not the facility will be allowed to continue to be used as a nursing home.

This situation is further exacerbated by the fact that the Medicare program has published regulations which reflect the Department's apparent attempt to exercise jurisdiction over the sale of an existing facility, while the Medicaid program has not. As a result, while the effective date of the satutory provision was originally October 1972, the implementation through the regulatory process is still incomplete. We would urge the Sub-Committee to give consideration to clarifying this particular problem in S. 3205.

B. Effective Dates

We would strongly encourage the Sub-Committee to review the time frame of the effective dates of the provisions of S. 3205. There seem to be continuous problems with effective dates once legislation is enacted involving the Medicaid and Medicare programs. The regulations implementing Section 249 of P.L. 92–603 are a prime example. While the provision was passed in 1972, the final regulations were not issued until July 1, 1976, which was the effective date of the provision. In acknowledging that the States would not be able to meet the requirements of the regulations, the Department of Health, Education and Welfare has attempted by regulation, to delay the effective date to January 1, 1978.

In other cases, the effective date has occurred shortly after the legislation is enacted or has actually passed. This has resulted in compliance problems for providers which could have added implications as a result of the provisions set forth under Sections 31, 40, and 45.

We would, therefore, recommend, Mr. Chairman, that the Sub-Committee consider:

1. Establishing effective dates for financial or cost related provisions on an accounting year basis.
2. Requiring that the Department of Health, Education and Welfare submit progress or status reports to the Sub-Committee when extended effective dates are used for a provision.

IV. CONCLUSION

Mr. Chairman, again we appreciate the initiative which you have taken with S. 3205, and in holding these hearings. The need for reforming the administrative structure of the Medicaid and Medicare programs is clear. S. 3205 represents a large step in that direction.

In so far as reforming the payment system for nursing homes is concerned, we are of the opinion that the authority is already available under amendments to the Social Security Act developed by the Senate Finance Committee in 1972. Specific authority exists under both Sections 222 and 249 of P.L. 92–603 for developing new methods and reforming the payment systems for nursing homes participating in the Medicare and Medicaid programs. The problem, however, has been in securing the implementation of the provisions by the Department of Health, Education and Welfare.

It is paramount that an effective prospective payment system be developed and tested before a national health insurance program is established. That system must balance incentives with disincentives in order to encourage the provider to meet the general goal of providing quality care at a reasonable cost. In order to accomplish that objective, experimentation and implementation needs to start now on various systems and concepts under Sections 222 and 249 of P.L. 92–603.

We would recommend that any further legislative initiatives involving nursing home payment systems other than those of a clarifying nature as suggested in our statement, be held in abeyance at this time. On that basis, we concur with the scope of the reform proposed in Section 10 of S. 3205 of limiting itself initially to hospitals.

Mr. Chairman, again let me say that I sincerely appreciate this opportunity to present our comments to you and the members of the Sub-Committee on S. 3205. If you have any questions concerning our statement, I will be happy to attempt to answer them.

Thank you.

Mr. ROSTENKOWSKI. Our next witness is Thomas Ainsworth.

STATEMENT OF THOMAS H. AINSWORTH, JR., M.D., ILLINOIS MASONIC MEDICAL CENTER; ACCOMPANIED BY JAMES H. OBRIECHT, CPA

Dr. AINSWORTH. Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Welcome to the committee, Dr. Ainsworth. It is nice to see you here.

Dr. AINSWORTH. I am Thomas H. Ainsworth, Jr., M.D., I am medical director of the Illinois Masonic Medical Center in Chicago.

With me is James Obriecht, director of finance of the Illinois Masonic Medical Center. We believe our institution is representative of the urban community hospitals which provide the highest percentage of health care under programs of medicare and medicaid.

Our institution is a 566-bed nonprofit teaching medical center affiliated with the University of Illinois serving an inner city community whose per capita income is below the national average; 24 percent of the families being served at IMMC are below the $5,000 poverty level. Because of the social and economic level of our service area, approximately 60 percent of our patient days are covered by Government programs, Titles XVIII, XIX, and V. This high percentage magnifies the problems of reimbursement encountered in these programs and permits a sharper focus on some of the inequities and disadvantages of the present cost reimbursement mechanism. For this reason we feel that we can provide important input to the committee.

We would like to stress five points today.

One, that inflation of hospital costs is a minor cause of increased health expenditures.

Two, the current cost reimbursement mechanism is a major cause of such increases.

Three, the only cost control mechanism that will not be counterproductive is utilization control.

Four, the current cost reimbursement mechanism has financial disincentives to appropriate utilization; and

Five, the utilization control mechanism with the best chance of success is prospective case rate reimbursement because of its built-in financial incentives.

We agree that the rising costs of hospital care continues to be the major factor.

We would agree with former HEW Secretary Weinberger that "the faulty design of medicare and medicaid" is a, if not the, principal culprit responsible for inflation in health care costs, but we do not believe that inflation in health care costs is a major cause of the marked rise in health care expenditures. We believe this rise represents an increased demand by a better educated public for medical care services and the elimination of many financial barriers to access to these services.

The white paper entitled "The Problem of Rising Health Care Costs" in the form of a staff report released in April 1976 by the Council on Wage and Price Stability indicates a growing governmental concern with the percentage rise in medical care services as a component of the Consumer Price Index.

Concern was expressed that medical care services in calendar 1975 rose 10.3 percent; and even more concern was expressed that hospital service charges rose 13 percent.

We believe that the Consumer Price Index is not a valid index of inflation in hospital costs or charges. Inflation is present only when there is a rise in the cost of the same goods and services over time. Even in a 1-year period, the services which make up the hospital service charges reflect a marked change not only in the quantity, but the quality of services provided.

You have to remember the half-life of medical knowledge and technology today is only 6 years. From year to year that new knowledge and technology has been converted into patient care services.

The cost of these hospital service components usually does not reflect the same service from year to year. Such an index is like comparing the cost of a black and white television set in 1974 to the cost of a color set in 1975.

The largest component making up the hospital service charges in the Consumer Price Index is the charges for a semiprivate room.

We would like to tell you what actually goes into that semiprivate room charge from our hospital viewpoint.

First, this component reflects the cost to the hospital for the purcase of goods, many of which have shown cost increases higher than the overall inflationary rate of the 7-percent Consumer Price Index. Food and fuel are examples of this.

In addition, this item also reflects increased cost to the hospital of items the hospital has been expected to "absorb."

Hospitals have been expected to "absorb" the costs of new programs, standards, and controls legislated at both the Federal and State levels where appropriations have not paralleled the costs. For example, PSRO appropriations have been approximately $50 million at the Federal level annually. Cost to hospitals for PSRO programs will be over $500 million annually.

Hospitals have to absorb the cost of all free care and unreimbursed expenses. This will cost our hospital $7.5 million in fiscal year 1976. This represents approximately 16 percent of our total budget and $47 per day in room rate charges.

However, $27 of the $47 per day cost for room and board represents the fact that medicare and medicaid do not recognize free care and bad debts as a reimbursable cost in the current reimbursement mechanism. (See attachment A.)

All other industries recognize free care and bad debts as a "cost" of doing business.

This represents one of the basic inequities in the present cost reimbursement system. It is a major reason why hospital charges have increased since the start of the medicare program in 1965.

These increased room charges only affect the private patients not covered by Government programs. These private patients at Illinois Masonic (40 percent) not only pay for their own way, but must pay for all the free care and bad debts as well. In effect the individual private patient and private insurance companies are subsidizing Federal programs, because Federal programs do not pay their fair share of total hospital costs under the present reimbursement mechanism.

If anticipated Federal legislation is enacted which will limit payments to hospitals by medicare to cost increases reflected by the Consumer Price Index of 7 percent, then any actual cost increase to the hospital will again require increases in hospital room and board charges.

This will be necessary in our institution because we have really reached the limit of costs we can absorb and still economically survive.

This legislation will in effect increase the subsidy of Federal programs by the private taxpayer, but not all private taxpayers, only those who are unlucky enough to need health care services. The effect of such legislation would inflate the hospital service charges component of the consumer price index.

The greatest cost increases in this next year in hospital costs and charges will be related to the malpractice crisis. Over the past 10 years Illinois Masonic Medical Center has paid from $100,000 to $300,000 in annual premiums for malpractice insurance (an allowable cost, 60 percent of which was reimbursed by Government programs). Over this same 10 years the insurance company paid out in claims a total of about $300,000 (equal to one annual premium). We were informed this year the night before the rates changed that our annual premium would be increased to $2,800,000, a 900-percent increase.

Had Illinois Masonic not moved to the self-insurance route, this added cost of malpractice premium increase would have raised semi-private room rates $14.66 per day.

Whatever the cause, it would appear that investigation of the cause and legislative relief for the present malpractice crisis would be in the self-interest of the Government as a third party purchaser of care. Since malpractice coverage and health insurance are handled by different companies, maybe Congress should consider requiring all insurance companies which serve as intermediaries for Federal programs to also make available to the providers malpractice insurance at reasonable cost.

Another component which is raising hospital service charges is the cost of borrowing money for cash flow purposes due to the payment mechanisms of the medicaid programs.

It is strongly recommended that the same Federal legislation and regulations which promulgated the medicaid program require the States to implement programs similar to medicare to make payments within reasonable time limits.

Another element that appears in the hospital service charges component which reflects an inequity in the present medicare reimbursement system is that the present system provides for no margin for repayment of debt principal or to finance technical obsolescence or new improvements in the techniques of medical treatment.

It is inequitable for medicare to pay 11.8 percent of equity capital to proprietary hospitals and allow absolutely no margin for nonprofit institutions.

We would summarize the above paragraphs by concluding that the increase in health care expenditures by the American public reflects a combination of increases in price, population growth, growth in utilization of medical services, and many quality improvements in the health care delivery system.

There is no accurate data which would substantiate the claim that there is false inflation in the costs of hospital services. There is much more evidence to support the statement that the current medicare and medicaid reimbursement mechanisms, because of the inequities and certain disallowable costs, have escalated hospital charges. This in effect has caused an increasing subsidization of these Federal programs by the private consumer of health care services and by other third party purchasers of care.

It would appear that the American public is stating its priorities, that it wishes to use more and higher quality medical care services, and that the increasing percentage of gross national product reflects these priorities.

There is need, therefore, for public debate to develop a rational national health policy as a guide for the providers of health care services. A national health policy which states, "Thou shalt not spend more than 8.3 percent of the gross national product on health care services" is no longer a viable concept.

There is no doubt in our mind that the present American health delivery system can provide as much of the gross national product as the American public wishes to purchase. There is also no doubt that the present third party system for the purchase of health care services irrespective of the reimbursement mechanisms has removed the health care system from the usual market controls. Our present health care economic system, therefore, is characterized more by a demand-pull than a cost-push increase in expenditures.

In such a system there is always the danger of overutilization of resources, and it would, therefore, be prudent if the Government wishes to limit increasing expenditures for health care to develop an equitable method of utilization control.

To develop a rational mechanism for the control of overutilization of health care services, it is necessary to review the historical development of such controls and evaluate their past effectiveness.

Several mechanisms have been used. The first was to limit benefits to those which were actuarily insurable. This explains why inhospital benefits were available when those for ambulatory care were not.

The control of utilization of inhospital benefits then became necessary because of these habit patterns. This resulted in claims review by third party purchasers of care. Historically claims review has concentrated on cost control without concern for quality; only two parameter screens have been used: (1) total charges, and, (2) length of stay.

When the Federal Government because a third party purchaser of care with the advent of medicare and medicaid in 1965, it adopted these same mechanisms from other third party purchasers of care, particularly Blue Cross. Benefits were again limited to what was actuarily insurable, and the intermediaries were given the function of providing claims review for Federal programs of medicare. States established similar programs for medicaid. The initial utilization review programs mandated for hospitals under medicare was designed to have physicians act as "deputies" for third party purchasers of care to control the utilization of benefits. Since physicians were motivated to meet all the real needs of their patients, they were placed in the untenable position of controlling services they felt were medically necessary. This system utterly failed.

An attempt was made to correct this discrepancy in differences in motivation in the PSRO legislation. Physicians were asked to determine the medical necessity of care; intermediaries were to continue to review claims for appropriateness of benefits and eligibility of beneficiaries. However, the current implementation of the PSRO system allows determination of medical necessity to be made on relatively subjective criteria. By this I mean that even with the development of objective criteria to measure quality of care, it will be difficult for physicians ever to say that specific ancillary tests and services are not medically necessary in individual cases. Physicians will always resist the development of "standards" of allowable and nonallowable tests and services in the diagnosis and treatment of specific diseases. This is considered "cookbook" medicine. However, physicians are willing to be judged by the outcomes they achieve. Standards can be developed for mortality rates and morbidity rates for specific diseases. These are considered outcome measurements of quality. If the determination of medical necessity in the PSRO system is ever to become a viable cost control and utilization control mechanism, then efficiency as expressed by length of stay and cost of care must also be considered hand-in-hand with elements of quality.

The true determination of medical necessity must eventually permit physicians to make these decisions on the basis of the cost-benefit of particular elements of care.

A PSRO must be able to justify increased length of stay and total charges on the basis of decreased mortality and morbidity rates.

Increased costs of care by increased use of ancillary services and longer periods of stay in the hospital must be justified by appropriate decreases in mortality and morbidity rates. Arbitrary controls of cost elements alone are unjustified.

While we believe that all types of prospective rate reimbursement experiments should be undertaken, we wish to caution against the use of a system which is based on per diem rates. Per diem rates are an invalid and misleading index of the cost of care. Per diem rates are not accurate, because they vary considerably with patient mix, the sophistication of the health care providers, and the quality of the care provided within the institution. For example, at Illinois Masonic we know that it cost $550 less in 1975 to have a coronary bypass operation than it did in 1974, and that it cost $450 less to have your gall bladder removed, despite a $9 per diem rate increase.

Incidentally, we have 4-year data on case rate. I think we are the only hospital in the country to have that.

Another argument against per diem rates is that current medicare and medicaid utilization review and PSRO regulations are based on disease specific—case—data.

The incentive in these controls is to decrease length of stay. This means that care is intensified on a per diem basis and results in higher per diem costs but lower per case cost. To place a ceiling on per diem costs makes these two programs totally counterproductive.

We believe that prospective case rate is the most viable and logical mechanism for cost reimbursement. It is also the best and most equitable mechanism to provide effective cost control. It has the same financial incentives as the health maintenance organization (HMO) concept without requiring a redesigning of the present delivery system. To be acceptable, however, case rates should be set on the basis of regional norms developed from data collected on outcome elements of quality which would then determine the appropriate cost.

We suggest the use of specific outcome elements which would permit this determination; namely, mortality rate, morbidity rate, length of stay, and total charges broken down into five cost components: lab, X-ray, drugs, special procedures, and administrative charges.

Administrative charges reflect room and board, nursing services, and other nonpatient care costs. This component would vary with the institutional size and functional classification.

All other elements would be standard for a region.

Attachment B shows how this system has been implemented at IMMC for utilization review purposes. However, before this can be implemented, it will be necessary to collect these data on a regional basis to develop regional norms. Since such data is absolutely necessary to make valid decisions of medical necessity in the PSRO system, we suggest that this be the source of these data.

We further suggest that experiments in prospective case rate reimbursement methodology be undertaken before any prospective rate reimbursement program is implemented.

Thank you very much for the opportunity of presenting our testimony.

We will be glad to answer any questions that you may have, Mr. Chairman.

[The prepared statement and attachments follow:]

STATEMENT OF THOMAS H. AINSWORTH, JR., M.D., AND JAMES H. OBREICHT, CPA, ILLINOIS MASONIC MEDICAL CENTER

Mr. Chairman, I am Doctor Thomas H. Ainsworth, Jr., Medical Director of the Illinois Masonic Medical Center in Chicago, Illinois. I have had twenty years of experience as a practicing physician and an additional six years in medical administration. For three years I was Associate Director of the American Hospital Association and was the principal author of the publication, "Quality Assurance Program for Medical Care in the Hospital," published by the Association in 1972 and updated in 1974. With me today is Mr. James Obriecht, Director of Finance of Illinois Masonic Medical Center. Mr. Obriecht has had fifteen years of experience as a CPA with the accounting and consulting firm of Arthur Andersen and Company, where he specialized in financial aspects of health care delivery systems. Both of us represent the board, administration, and medical staff of the Illinois Masonic Medical Center. We believe that our institution is representative of the urban community hospitals which provide the highest percentage of health care under the federal programs of Medicare and Medicaid.

Our institution is a 566 bed nonprofit teaching medical center affiliated with the University of Illinois serving an inner city community whose per capita income is below the national average; 24 percent of the families being served at IMMC are below the $5,000 poverty level. Because of the social and economic level of our service area, approximately 60 percent of our patient days are covered by government programs, Titles XVIII, XIX, and V. This high percentage magnifies the problems of reimbursement encountered in these programs and permits a sharper focus on some of the inequities and disadvantages of the present cost reimbursement mechanism. For this reason we feel that we can provide important input to the Committee.

We have noted with interest the background information regarding the hearing topic provided by the Subcommittee. We agree that the rising cost of hospital care continues to be the major factor driving up Medicare expenditures. Yet we are very concerned with the implication that these increased expenditures are due entirely to inflation in health care costs. We further believe to conclude that "the method of retrospective cost reimbursement encourages hospitals to spend freely, since whatever costs are incurred tend to be reimbursed as reasonable costs and leads necessarily to the proliferation and inefficient employment of facilities, over consumption of services, and a general lack of cost consciousness among consumers and providers," is a naive, misleading oversimplification of the problem.

Total health care expenditures have tripled in the decade since 1965 when Medicare and Medicaid were introduced. In 1965 total health expenditures were $39 billion, representing 5.9 percent of gross national product. In 1975 total expenditures were $118.5 billion, representing 8.3 percent of gross national product. These increases do not reflect an increase in price alone, but also reflect population growth, increases in utilization of medical services, and quality improvements in medical care.

Per capita expenditures for personal health care by the federal government rose from $14.44 in 1965 to $131.92 in 1975, an increase of 813.6 percent. Direct payment by the individual for personal health care services rose from $89.37 in 1965 to $155.10 in 1975 a 73.5 percent increase in expenditures. Direct payments by individuals have decreased from 52.5 percent of total health care expenditures to 32.6 percent in this decade, representing a marked shift to third party purchase of care by the federal government, an increase in the over-65 population, and an increase in benefits in federal health care programs.

This same decade has witnessed an increased utilization of medicare care services by an educated and well informed public. Hospital inpatient admissions have seen an annual increase of approximately 7 percent, and the use of ambulatory care services that are hospital-based has increased approximately 15 percent annually.

In this past ten years we have also seen an increase in geometric proportion of the knowledge and technology in the health care field. Educators now estimate that in 1975 the half-life of medical knowledge is only six years. This new knowledge has been rapidly translated into new and higher quality medical care services by the providers of health care, and the availability of these new services has been well communicated to the American public by our modern communications system. This means that one-half the knowledge which health care providers now have and the parallel technological improvements used in providing medical care services today were unknown in 1970.

We would agree with former HEW Ssecretary Weinberger "that the faulty design of Medicare and Medicaid" is a, if not the, principal culprit responsible for inflation in health care costs, but we do not believe that inflation in health care costs is a major cause of the marked rise in health care expenditures. We believe this rise represents an increased demand by a better educated public for medical care services and the elimination of many financial barriers to access to these services.

The white paper entitled, "The Problem of Rising Health Care Costs," in the form of a staff report released in April 1976 by the Council on Wage and Price Stability indicates a growing governmental concern with the percentage rise in medical care services as a component of the consumer price index. They provide data that shows that the consumer price index for all items showed an annual increase of 7.0 percent in calendar year 1975. They point out that if medical care were omitted from the index, the increase would have been only 6.8 percent. Concern was expressed that medical care services in calendar 1975 rose 10.3 percent; and even more concern was expressed that hospital service charges rose 10.3 percent, since hospital services charges represent approximately 40 percent of total health care expeiditures.

We believe that the consumer price index is not a valid index of inflation in hospital costs or charges. Inflation is present only when there is a rise in the cost of the same goods and services over time. Even in a one-year period, the services which make up the hospital service charge component reflect a market change not only in the quantity, but the quality of services provided. The cost of these hospital service components usually does not reflect the same service from year to year. Such an index is like comparing the cost of a black and white television set in 1974 to the cost of a color set in 1975.

The largest component making up the hospital service charges in the consumer price index is the charges for a semi-private room. This component reflects the cost to the hospital for the purchase of goods, many of which have shown cost increases higher than the overall inflationary rate of the 7 percent consumer price index. Food and fuel are examples of this. In addition, this item also reflects increased cost to the hospital of items the hospital has been expected to absorb.

Hospitals have been expected to "absorb" the costs of new programs, standards, and controls legislated at both federal and state levels where appropriations have not paralleled the costs. For example, PSRO appropriations have been approximately $50 million at the federal level annually. Cost to hospitals for PSRO programs will be over $500 million annually. In the HASP program in Illinois (the Medicaid utilization review program), costs have varied from $9 to $15 per case. IMMC's cost for HASP review was an additional $4.92 per case in 1975. Cost of all non-Medicaid in-hospital utilization review was $3.80 per case.

Hospitals have to absorb the cost of all free care and unreimbursed expenses. This will cost our hospital $7.5 million in fiscal year 1976. This represents approximately 16 percent of our total budget and $47 per day in room rate charges. This amount represents a substantial increase over fiscal year 1975. We believe that inflation and unemployment in the population we serve have contributed to this increased number of medically indigent. However, $27 of the $47 per day cost for room and board represents the fact that Medicare and Medicaid do not recognize free care and bad debts as a reimbursable cost in the current reimbursement mechanism. (See Attachment A.)

Federal regulations under the Hill Burton program require that hospitals provide a certain amount of free care or maintain an "open door" admission policy. Also under state and local licensing authorities, hospitals cannot refuse emergency care, the services for which result in a major portion of the free care of hospitals. All other industries recognize free care and bad debts as "cost" of doing business.

Traditionally hospitals have expected all of their patients to assume the costs of free care and bad debts in the rate structure. Medicare and Medicaid, however, do not recognize free care and bad debts as a reimbursable cost. This represents one of the basic inequities in the present cost reimbursement system. It is a major reason why hospital charges have increased since the start of the Medicare program in 1965. At Illinois Masonic this represents a $27 per day increase in the charges for a semi-private room. This disallowance of free care and bad debts is particularly unfair to a hospital such as ours with a large percentage of cost reimbursed patients (60 percent). Hospitals such as ours also have the free care and bad debt experience, due to the economic status of our patients. These increased room charges only affect the private patients not covered by government programs.

These private patients at Illinois Masonic (40 percent) not only pay for their own way, but many pay for all the free care and bad debts as well. In effect the individual private patient and private insurance companies are subsidizing federal programs, because federal programs do not pay their fair share of total hospital costs under the present reimbursement mechanism. But the saddest situation caused by this reimbursement mechanism is that we cannot afford to take more free patients and economically survive. We must turn the poor away, even though we have the facilities and staff to take care of more patients, thereby increasing our productivity. This is because every new free patient we take decreases our percentage of cost reimbursed patients in our total patient census; we, therefore, receive less reimbursement for our total costs for each new free patient we care for. We delivered 500 fewer babies last year, because we had to put a quota on our OB "set free" program which represents a charge of approximately 30 percent of the actual cost for a delivery.

If anticipated federal legislation is enacted which will limit payments to hospitals by Medicare to cost increases reflected by the consumer price index of 7 percent, then any actual cost increase to the hospital will again require increase in hospital room and board charges. This will be necessary in our institution because we have reached the limit of costs we can absorb and still economically survive. This legislation will in effect increase the subsidy of federal programs by the private taxpayer, but not all private taxpayers, only those who are unlucky enough to need health care services. The effect of such legislation would inflate the hospital service charges component of the consumer price index.

The greatest cost increases in this next year in hospital costs and charges will be related to the malpractice crisis. Over the past ten years Illinois Masonic Medical Center has paid from $100,000 to $300,000 in annual premiums for malpractice insurance (an allowable cost, 60 percent of which, or $60,000 to $180,000, was reimbursed by government programs). Over this same ten years the insurance company paid out in claims a total of about $300,000 (equal to one annual premium). We were informed this year that our annual premium would be increased to $2,800,000, a 900 percent increase! Sixty percent of this, or $1,680,000, would have been reimbursed as an allowable cost by governmental programs. However, because of our previous ten year experiences, in which average annual claims payment equalled one-tenth of our annual insurnace premium, prudent management suggested a self-insurance program with a $1 million deductible and reinsurance for possible claims over this $1 million level. The total cost of this self-insurance program is estimated to be approximately $600,000 annually, 60 percent of which, or $360,000, will be cost reimbursed by government programs. Only recently has the Social Security Administration provided a mechanism whereby costs held in escrow for self-insurance purposes can become an allowable cost under the Medicare program. However, many hospitals in the United States may be unable to self insure and simply pass on this increased cost to the third party purchaser of care. Had Illinois Masonic not moved to the self-insurance route, this added cost of malpractice premium increase would have raised semi-private room rates $14.66 per day.

The current malpractice crisis may also eventually lead to increased hospital costs. Many practicing physicians are finding it more and more difficult to obtain insurance coverage. A young surgeon just finishing his residency program in Illinois will have to purchase $36,000 worth of malpractice insurance before he dare open his door to see his first patient. This situation may eventually lead to hospitals having to subsidize physicians or place them on full-time employment in order for them to be able to practice. Our experience with malpractice would indicate that our premium increase of 900 percent this year is not related to claims payment. One must ask the question if it is more related to decreases in reserves of insurance carriers due to losses of investment of these funds. Whatever the cause, it would appear that investigation of the cause and legislative relief for the present malpractice crisis would be in the self-interest of the government as a third party purchaser of care. Since malpractice coverage and health insurance are handled by different companies, maybe Congress should consider requiring all insurance companies which serve as intermediaries for federal programs to also make available to the providers malpractice insurance at reasonable cost.

Another component which is raising hospital service charges is the cost of borrowing money for cash flow purposes due to the payment mechanisms of the Medicaid programs.

Not too many years after the beginning of the Medicare program, payment procedures had been developed to provide for payments within a reasonable time as provided for in the law. The periodic interim payment (PIP) system is a workable, relatively simple payment method which is being used by the Medicare program.

The Medicaid program, on the other hand, is disorganized, fragmented, and results in considerable delays in the payment process. It is strongly recommended that the same federal legislation and regulations which promulgated the Medicaid program require the states to implement programs similar to Medicare to make payments within reasonable time limits.

Another element that appears in the hospital service charges component which reflects an inequity in the present Medicare reimbursement system is that the present system provides for no margin for repayment of debt principal or to finance technical obsolescence or new improvements in the techniques of medical treatment.

At the beginning of the Medicare program, a 2 percent margin "over allowable costs" was paid to hospitals. This was discontinued in 1969 by Secretary Finch for budgetary reasons without the knowledge and recommendations of the Director of the Bureau of Health Insurance, Social Security Administration. While it is doubtful that a 2 percent margin is adequate for debt repayment or to cover the inflationary costs of technical obsolescence and improvements in medical treatment, some margin must be provided to meet these real financial requirements. In addition, under the present reimbursement principals proprietary hospitals are paid an additional amount for "return on equity capital." This amount is determined by taking one and one-half times the current interest rate on certain government bonds and is currently 11.8 percent. Not-for-profit hospitals, such as Illinois Masonic, must have some margin over cost, as noted above; it is inequitable for Medicare to pay 11.8 percent of equity capital to proprietary hospitals and allow absolutely no margin for non-profit institutions.

We would summarize the above paragraphs by concluding that the increase in health care expenditures by the American public reflects a combination of increases in price, population growth, growth in utilization of medical services, and many quality improvements in the health care delivery system. There is no accurate data which would substantiate the claim that there is false inflation in the costs of hospital services. There is much more evidence to support the statement that the current Medicare and Medicaid reimbursement mechanisms, because of the inequities and certain disallowable costs, have escalated hospital charges. This in effect has caused an increasing subsidation of these federal programs by the private consumer of health care services and by other third party purchasers of care. It would appear that the American public is stating its priorities, that it wishes to use more medical care services, and that the increasing percentage of gross national product reflects these priorities.

There is a need, therefore, for public debate to develop a rational national health policy as a guide for the providers of health care services. A national health policy which states, "Thou shalt not spend more than 8.3 percent of the gross national product on health care services," is no longer a viable concept.

There is no doubt that the present American health delivery system can provide as much of the gross national product as the American public wishes to purchase. There is also no doubt that the present third party system for the purchase of health care services irrespective of the reimbursement mechanisms has removed the health care system from the usual market controls. Our present health care economic system is, therefore, characterized more by a demand-pull than a cost-push increase in expenditures. In such a system there is always the danger of overutilization of resources; and it would, therefore, be prudent if the government wishes to limit increasing expenditures for health care to develop an equitable method of utilization control. There is some evidence that overutilization is a factor in increased health expenditures. However, the only "hard" data available at this time is a study done by the Department of Health, Education, and Welfare of the utilization of health care resources by federal employees from 1961 to 1968.

There are many factors which stimulate overutilization of hospital services in our present delivery system. Among these are lack of ambulatory benefits in the health insurance system and the convenience of one-stop shopping both for the patient consumer of health resources and the physician provider. Another factor is the shortage of primary care physicians in our present system. Eighty percent of practicing physicians are specialists. Specialists tend to be hospital oriented because this is the site of the technical support needed for the appropriate practice of their specialty.

To develop a rational mechanism for the control of overutilization of health care services, it is necessary to review the historical development of such controls and evaluate their past effectiveness. Several mechanisms have been used. The first was to limit benefits to those which are actuarily insurable. This explains why in-hospital benefits were available when those for ambulatory care were not. Over the last 30 to 40 years this has stimulated the use of in-hospital benefits; it has encouraged the patient to seek care in the hospital rather than the physician's office. The control of utilization of in-hospital benefits then became necessary because of these habit patterns. This resulted in claims review by third party purchasers of care. Historically claims review has concentrated on cost control without concern for quality; only two parameter screens have been used: (1) total charges and (2) length of stay.

When the federal government became a third party purchaser of care with the advent of Medicare and Medicaid in 1965, it adopted these same mechanisms from other third party purchasers of care, particularly Blue Cross. Benefits were again limited to what was actuarily insurable, and the intermediaries were given the function of providing claims review for the federal programs of Medicare. States established similar programs for Medicaid. The initial utilization review programs mandated for hospital care under Medicare was designed to have physicians act as "deputies" for third party purchasers of care to control the utilization of benefits. Since physicians were motivated to meet all the real needs of their patients, they were placed in the untenable position of controlling services they felt were necessary. This system utterly failed.

An attempt was made to correct this discrepancy in differences in motivation in the PSRO legislation. Physicians were asked to determine the medical necessity of care; intermediaries were to continue to review claims for appropriateness of benefits and eligibility of beneficiaries. However, the current implementation of the PSRO system allows determination of medical necessity to be made on relatively subjective criteria. By this I mean that even with the development of objective criteria to measure quality of care, it will be difficult for physicians ever to say that specific ancillary tests and services are not medically necessary in individual cases. Physicians will always resist the development of "standards" of allowable and non-allowable tests and services in the diagnosis and treatment of specific diseases. This is considered "cookbook" medicine. However, physicians are willing to be judged by the outcomes they achieve. Standards can be developed for mortality rates and morbidity rates for specific diseases. These are considered outcome measurements of quality. If the determination of medical necessity in the PSRO system is ever to become a viable cost control and utilization control mechanism, then efficiency as expressed by length of stay and cost of care must also be considered hand in hand with elements of quality.

The true determination of medical necessity must eventually permit physicians to make these decisions on the basis of the cost/benefit of particular elements of care. A PSRO must be able to justify increased length of stay and total charges on the basis of decreased mortality and morbidity rates. Increased costs of care by increased use of ancillary services and longer periods of stay in the hospital must be justified by appropriate decreases in mortality and morbidity rates. Arbitrary controls of cost elements alone is unjustified.

While we believe that all types of prospective rate reimbursement experiments should be undertaken, we wish to caution against the use of a system which is based on per diem rates. Per diem rates are an invalid and misleading index of the cost of care. Per diem rates are not accurate, because they vary considerably with patient mix, the sophistication of the health care providers, and the quality of the care provided within the institution. For example, at Illinois Masonic we know that it cost $550 less in 1975 to have a coronary bypass operation than it did in 1974, and that it cost $450 less to have your gall bladder removed, despite a $9 per diem rate increase.

Another argument against per diem rates is that current Medicare and Medicaid utilization review and PSRO regulations are based on disease specific (case) data. The incentive in these controls is to decrease length of stay. This means that care is intensified on a per diem basis and results in higher per diem costs but lower per case cost. To place a ceiling on per diem costs makes these two programs counterproductive.

We believe that prospective case rate is the most viable and logical mechanism for cost reimbursement. It is also the best and most equitable mechanism to provide effective cost control. It has the same financial incentives as the health maintenance organization (HMO) concept without requiring a redesigning of the present delivery system. To be acceptable, however, case rates should be set on the basis of regional norms developed from data collected on outcome elements of quality which would then determine the appropriate cost. We suggest the use of specific outcome elements which would permit this determination; namely, mortality rate, morbidity rate, length of stay, and total charges broken down into five cost components: lab, x-ray, drugs, special procedures, and administrative charges. Administrative charges reflect room and board, nursing services, and other non-patient care costs.

This component would vary with institutional size and functional classification. All other elements would be standard for a region. In establishing the classifications for various types of hospitals, provisions should be made for problems peculiar to inner city hospitals, such as security and theft losses, increased social services, free care, and bad debt. Attachment B shows how this system has been implemented at IMMC for utilization review purposes. However, before this can be implemented, it will be necessary to correct these data on a regional basis to develop regional norms. Since such data is absolutely necessary to make valid decisions of medical necessity in the PSRO system, we suggest that this be the source of these data. We further suggest that experiments in prospective case rate reimbursement methodology be undertaken before any prospective rate reimbursement program is implemented.

ATTACHMENT A

The following example based on the 1976 budget of Illinois Masonic Medical Center, illustrates what the average charge per patient day would be if M/M paid the costs of free care and bad debts. (M/M=Medicare/Medicaid)

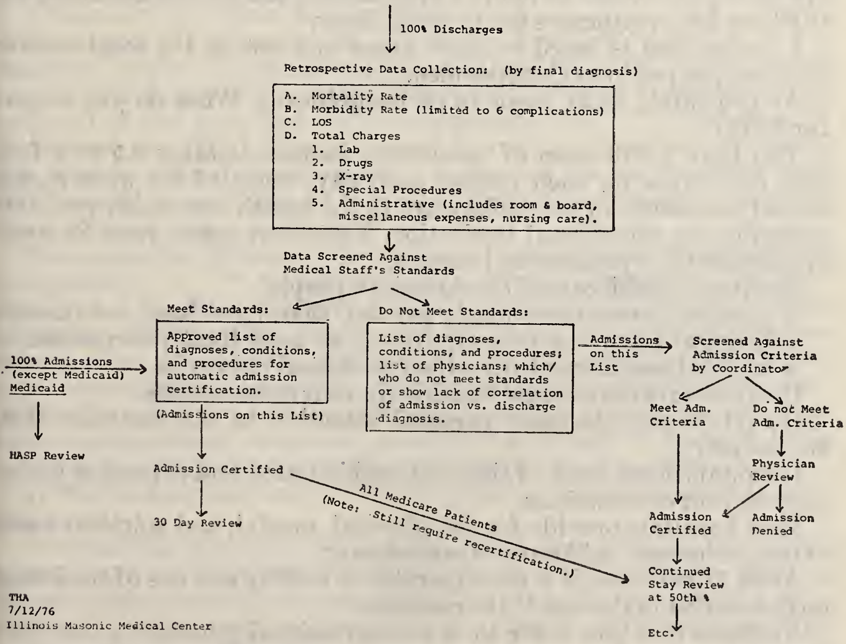
	1976 budget (thousands)			
	Medicare and medicaid does not pay full cost		Medicare and medicaid does pay free care, etc.	
	Total	Per day [1]	Total	Per day
Gross charges:				
Routine services	$21,000	$140	$17,000	$113
Ancillary services	18,000	120	18,000	120
Outpatient	4,000	27	4,000	27
Total gross revenue	43,000	287	39,000	260
Revenue deductions:				
Medicare and medicaid [2]	4,000	27		
Free care and bad debts	3,000	20	3,000	20
Total deductions	7,000	47	3,000	20
Net revenue	36,000	240	36,000	240
Other revenue	3,000	20	3,000	20
Total operating revenue	39,000	260	39,000	260
Total operating expenses	39,000	260	39,000	260
Net income				

[1] Based on 150,000 patient days with a 57-percent medicare/medicaid overall utilization rate.

[2] This deduction simply reflects the difference between gross charges and allowable costs for medicare/medicaid purposes because free care, etc. is not recognized by medicare/medicaid.

As can be seen by this example there would be a reduction of $27.00 per day in charges, if M/M would pay the costs of free care and bad debts. Said in another way, the non M/M patients have to pay an additional $27.00 per day due merely to the existence of the M/M patients in the Medical Center.

Attachment B


100% Discharges
Retrospective Data Collection: (by final diagnosis)
A. Mortality Rate
B. Morbidity Rate (limited to 6 complications)
C. LOS
D. Total Charges
1. Lab
2. Drugs
3. X-ray
4. Special Procedures
5. Administrative (includes room & board, miscellaneous expenses, nursing care).
Data Screened Against Medical Staff's Standards
Meet Standards:
Do Not Meet Standards:
Approved list of diagnoses, conditions, and procedures for automatic admission certification.
List of diagnoses, conditions, and procedures; list of physicians; which/who do not meet standards or show lack of correlation of admission vs. discharge diagnosis.
Admissions on this List
Screened Against Admission Criteria by Coordinator
100% Admissions (except Medicaid) Medicaid
HASP Review
(Admissions on this List)
Admission Certified
30 Day Review
All Medicare Patients
(Note: Still require recertification.)
Meet Adm. Criteria
Do not Meet Adm. Criteria
Physician Review
Admission Certified
Admission Denied
Continued Stay Review at 50th %
Etc.
THA
7/12/76
Illinois Masonic Medical Center

Mr. Rostenkowski. Any questions of the witness? Thank you very much.

STATEMENT OF DONALD I. GENT, EXECUTIVE DIRECTOR, WELBORN BAPTIST HOSPITAL, EVANSVILLE, IND.

Mr. Gent. Thank you, Mr. Chairman. I did submit a statement that I would like to have entered into the record.

Mr. Rostenkowski. Without objection, so ordered.

Mr. Gent. My name is Donald I. Gent. I live at 516 Oriole Drive, Evansville, Ind. I am the executive director of Welborn Baptist Hospital. I speak as an administrator of one of the major health care facilities in our country. Just a few indicators to acquaint you with our facilities: We serve Indiana, Illinois, and Kentucky; we are licensed for 487 beds; to replace our facilities and equipment would require $30 to $40 million; we have 1,000 full-time equivalent employees, 175 physicians, and 200 volunteers.

I will speak to the specific issues as outlined in your news release and their effects on one typical hospital (Welborn Baptist) in our country. My major thrust will be directed to the first issue: Factors contributing to the continuing rise in the cost of hospital care.

It costs on the average of $4.71 per hour to be a patient in a community short-term hospital in our country. We are fortunate in the State of Indiana where it costs $3.98 per hour. The cost seems insignificant in relationship to other purchased services and even wages in our country. As compared to 15 years ago, the increase is substantial. It costs a great deal more in some of the major cities.

To compare some of the costs, common laborers get $6 to $12 an hour; music teachers get $10 to $13 an hour; barbers, $12 to $15; beauty operators, $15 to $20 an hour; Congressmen, $20 to $22; Senators, $30 to $32 an hour; attorneys $35 to $60 an hour.

I realize that is based on 2,080 hours and not on the total number of hours you put in as Congressmen.

As you think, $4.71 seems to be insignificant. What do you receive for $4.71?

You have a full team of specialists. In fact, it takes 2.5 to 3 full-time employees for each patient each day. Some of the most highly skilled specialists in our society are in the health care field; probably exceeding an educational institution. They have spent years in preparation for their professional careers.

Improved health care of the American people.

A hospital serves more meals per day than most local restaurants.

A hospital fills more prescriptions than most local pharmacies.

A hospital uses more utilities than most local industries.

Hospitals are the cleanest facilities in your communities.

Hospitals provide more personal attention to the customer than any industry.

Hospitals house some of the most sophisticated and expensive equipment in your communities.

Most hospitals provide for the physical, mental, and spiritual needs of our customers, unlike any other industry.

At $4.71 per hour, it is incomparable in quality and one of the lowest on the market in the cost to the consumer.

Numbers that you relate to as a congressional committee, that were quoted to you in previous testimony, are that health care expenditures for the fiscal year ending June 30, 1975, per the Social Security

Administration Office, were $118.5 billion, 8.3 percent of the gross national product, or $547 for every man, woman, and child. Health expenditures climbed about $9 billion a year until 1974. The $14.5 billion jump for 1975 is the largest on record. The Federal Government spent $38.8 billion for programs under HEW, Veterans' Administration, and Department of Defense in 1975, an increase of 22.2 percent from 1974. Major increases were in the medicare and medicaid programs. State and local governments spend considerably less than the Federal Government: $16.1 billion. As in the past year, hospital care took the largest share of health care expenditures, $46.4 billion in 1974. Physicians services were second with $22.2 billion, compared with $19.6 billion previously.

These are startling amounts. They are reason for concern. In the main streams, the increases are from many sources: Inflation (cost increases to health care providers); new dollars for new programs—programs which Congress previously approved; more patients served requiring more dollars of Government expenditures. In 10 years, medicare-medicaid patients served have almost doubled; compliance with Government regulations; sicker patients as a result of utilization requirements and emphasis on outpatient services; increased demand for care; improved quality of care; greater expectations from public and patients; third-party payment mechanism which reimburses on a deficit basis; the energy crunch has reached the sick patient; malpractice cost increases; and many others.

The increases need to be evaluated and expressed properly to the public. To express gross percentages in relationship to gross national product is misleading. It stirs the emotions of people. We must begin to define, clarify, explain the increases.

We would not concur with HEW Secretary Weinberger in his testimony before the subcommittee on June 12, 1975, during which he said: "I firmly believe that the faulty design of medicare and medicaid is the principal culprit responsible for * * * inflation in health care cost. With the guaranteed Government payment of health care cost in virtually any amount submitted by the provider and with normal market factors absent in the health care area, inflation was bound to happen, and it did."

This statement seems to express that hospitals spend carelessly and irresponsibly. (" * * * virtually any amount submitted by the provider * * *."). This rhetoric serves no useful purpose other than confusing the American people. We do concur that retrospective reimbursement is unfair to hospitals. The current system of reimbursement, retrospective reimbursement, in your terminology is called deficit spending. Let me illustrate: "Every Federal and State health dollar for services rendered costs every nonmedicare patient $0.10–$0.15. This is deficit spending as a result of retrospective reimbursement."

At Welborn, as the result of deficit spending, nonmedicare-medicaid was paid:

You can see over the last 5 years, fiscal year ending, the dollar amounts are amounts discounted off the medicaid patients. That is the per patient stay or the per patient amount, and how much a nonmedicare patient paid on their bill as a result of the retrospective system at Welborn Hospital.

That is to say in 1976, ending June 30, 1976, $7.93 for every patient day, for 40 percent of our patients at Welborn Hospital, was charged off as a discount.

Then I want to show you Indiana's—there was mention this morning in testimony of Indiana's prospective reimbursement system. It considers the hospital's needs. It is on a voluntary basis. In Indiana, we have 139 hospitals: 113 are community short-term hospitals; 26 are long-term or specialty hospitals.

For Indiana, per patient day it is $95.43; in the United States on the average it is $113.21.

If you go to your supplement on page 1, it gives you more information about the Indiana system.

Indiana's voluntary prospective system has perfected their costs in the State.

For example, in 1960, the per patient day cost was $32.93 in Indiana. In the United States it was $32.23; or in Indiana it was 2.2 percent more.

In 1974 it was $95.43 in Indiana and in the United States it was $113.21, a decrease of 15 percent for a case day, a hospital stay in 1960 in Indiana, $250.27; for the United States, $244.95; and that was at 2 percent. In 1974, the hospital stay was $744.35 compared to $883.04 for a 15-percent decrease in the State of Indiana.

In a recent hospital purchasing management journal, it was stated, "Spending for hospital supplies increased by a whopping 25 percent in 1975."

How did it affect Welborn Hospital? Here are a few examples—and I have included a schedule on a page and a half for typical supplies Welborn Hospital bought for the last 5 years.

You can run down on the right side the percentage of increases or various supplies at Welborn Hospital. For example, elastic bandages, the increase has been 79 percent in the last 5 years.

It varies from 20 some percent to 70 or 80 percent in supplies.

On page 9, another interesting bit of information from our files is that we just completed a survey or inventory of our equipment and building costs with a professional organization.

As of June 30, 1975, our recorded historical cost was $19,064,252. This is the amount used for reimbursement in the retrospective system.

However, our projection of what it would cost to replace today would be $32,546,700. I have also listed items of equipment that I thought you might be interested in reviewing. If you will go to page 2 of the supplement, it shows some items of equipment.

In the standard radiographic fluoroscopy room, in 1960 to equip a room at a hospital like Welborn it would have cost $18,059. In 1966, to equip that same room, it was $24,146; to equip it in 1971, it was $73,838; and in 1976, to equip the same room, it would be $101,820.

So, in 16 years, to equip a fluoroscopy room in a hospital, the increase was 546 percent, or 35 percent per year.

I jotted down on the side of my sheet just some information I thought you might be interested in reviewing.

Assuming that we bought an X-ray machine in 1966 for $24,146, we would have recovered all of that, probably in 10 years, if that would be the life of that piece of equipment in depreciation.

If we had also taken the amount of money and invested all of it at 6 percent, we would have earned another $8,000 in the way of interest income; and, if you apply an average of the medicare patients that we would have at Welborn Hospital—and I would just estimate over the last 10 years about an average of 30 percent—we would recover through depreciation and interest income approximately $9,644 through the medicare-medicaid program on an item of $24,146.

If we had to go out and buy that piece of equipment today, it would cost $101,000, when the total number of patients on the average would be approximately 30 percent.

Other cost increases. On page 10, on insurance costs, 1974, we paid $81,000; 1975, $89,000; 1976, $228,000 for an increase in 2 years of 208 percent.

In drug cost, in 1974, we paid $256,000; 1975, $268,000; and in 1976, $389,000, for a 50-percent increase.

Another item I would like to stress is the energy crunch which has reached the sick patient. Today at Welborn, it costs $3 for every patient day, and on the average, $277 for each hospital stay for natural gas and electricity. We envision an increase of two to three times our present utility cost over the next 5 to 10 years. In addition, we can anticipate an enormous capital outlay for conversion to an alternate source of energy.

Our hospital has been asked to drastically reduce (60 percent) our natural gas consumption by November 1976. The announcements have vacillated from no curtailment to a 60-percent reduction. Quantity entitlement announcements are received based on availability.

The capital expenditures will be great. The operating cost, astronomical. The only method of paying for the new systems will be through increased charges to patients.

I gave you the increase in the costs of natural gas at Welborn Hospital. You can see the increase through 1972 to 1976. The bottom of the page shows our electricity costs.

To project the future in the way of operating costs based on the present prices for utilities, today it costs Welborn $347,300 for natural gas and electricity. If we convert 100 percent to fuel oil, it will cost $647,000 and raise your patient day costs from $3 to $3.39 for a whole stay of $48.50.

If we convert to total electricity, our total bill will be $687,400; and to coal, $524,000.

I thought you might be interested in that kind of information.

Recently, on page 13, in the middle; the Council on Wage Price Stability reported to the President, "It is a national economic problem, not just a health care problem."

The American Hospital Association recently called for a thorough analysis of cost in a statement submitted to the Democrat Platform Committee. They said, "Because there is widespread misunderstanding of why health care costs are rising, increased health care cost must be examined in light of the improved health of the American people." The AHA pointed out that HEW statistics confirm that our health care system has produced a steady decline in the national mortality rate in the past several decades.

William E. Simon, U.S. Secretary of the Treasury, seems also to indicate that it is a national economic problem, not just a health care problem, when he told the Tri-State Hospital Assembly's opening session recently that the burden of paying the Government's bills has become so heavy for taxpayers that many are now in open rebellion.

It is quite obvious that we have an economic problem that is contributing to the health care cost. To separate out just the health care industry and reduce cash flow or reimbursement through a cap on national programs will not solve the problem.

I would like to add that the information going to the press is misleading. It is time we joined hands in community education to evaluate increases in cost and express them properly to the public, to express programs in billions in relation to gross national product is unfair to the public. We must begin to clarify, define, explain hospital costs. To hold the health industry together reliably for increased costs is like standing in the middle of a raging forest fire blowing out a match. The health care industry is not the major culprit for inflation nor is medicare or medicaid. We have a major economic problem that is the culprit. We must solve it together and not expect the health care industry to solve the problem. To single out the health industry will frustrate, stifle, choke, and bring the health care system to their knees. We must get on with some programs before another step is taken to control or add new programs or even think about national health insurance for our country.

I would suggest two or three. One has not been stressed very much today. The first one is a complete reorganization of all our health care programs prior to the implementation of a single new program. No. 2 is the establishment of a voluntary or other method of implementating prospective reimbursement based upon total financial needs of the institution. The third one, which I haven't heard much about today, and that is community health education programs.

I am aware that Congress has enacted some legislation to assist in communicating health care costs to our country.

I am aware of the amounts in the particular act. They are very small. We are involved in looking into that situation now from the standpoint of trying to clarify in our own communities what health care costs are in order to help the community.

Thank you very much for the opportunity you have given me.

[The prepared statement and supplement follows:]

STATEMENT OF DONALD I. GENT, EXECUTIVE DIRECTOR, WELBORN MEMORIAL BAPTIST HOSPITAL, INC.

My name is Donald I. Gent. I live at 516 Oriole Drive, Evansville, Indiana. I am the Executive Director of Welborn Baptist Hospital. I speak as an administrator of one of the major health care facilities in our country. Just a few indicators to acquaint you with our facilities: We serve Indiana, Illinois, and Kentucky; we are licensed for 487 beds; to replace our facilities and equipment would require \$30–40 million; we have 1,000 full-time equivalent employees, 175 physicians, and 200 volunteers.

I will speak to the specific issues as outlined in your news release and their effects on one typical hospital (Welborn Baptist) in our country. My major thrust will be directed to the first issue: Factors Contributing to the Continuing Rise in the Cost of Hospital Care.

It costs on the average of \$4.71 per hour to be a patient in a community short-term hospital in our country. We are fortunate in the State of Indiana where it costs \$3.98 per hour.[1] The cost seems insignificant in relationship to other purchased services and even wages in our country. As compared to fifteen years ago, the increase is substantial. It costs a great deal more in some of the major cities.

---

[1] Hospital Digest, published by Branch Advertising Production, Inc., Indianapolis, Indiana. Vol. 1, No. 1, Page 1.

To compare: Common labor, $6–12; music teacher (private lessons), $10–15; barber, $12–15; plumber, $12–20; beauty operator, $15–20; Congressman (salary only), $20–22; Senator (salary only), $30–32; attorney, $35–60; and consultant, $35–60.

As you think, $4.71 seems to be insignificant. What do you receive for $4.71?

You have a full team of specialists; in fact, it takes 2½–3 full-time employees for each patient each day. Some of the most highly skilled specialists in our society are in the health care field; probably exceeding an educational institution. They have spent years in preparation for their professional careers.

Improved health care of the American people.

A hospital serves more meals per day than most local restaurants.

A hospital fills more prescriptions than most local pharmacies.

A hospital uses more utilities than most local industries.

Hospitals are the cleanest facilities in your communities.

Hospitals provide more personal attention to the customer than any industry, including the church.

Hospitals house some of the most sophisticated and expensive equipment in your communities.

Most hospitals provide for the physical, mental, and spiritual needs of our customers, unlike any other industry.

At $4.71 per hour, it is incomparable in quality and one of the lowest on the market in the cost to the consumer.

Numbers that you relate to as a congressional committee are that health care expenditures for the fiscal year ending June 30, 1975, per the Social Security Administration office, were $118.5 billion, 8.3% of the Gross National Product, or $547 for every man, woman, and child. Health expenditures climbed about $9 billion a year until 1974. The $14.5 billion jump for 1975 is the largest on record. The federal government spent $38.8 billion for programs under H.E.W., Veteran's Administration, and Department of Defense in 1975, an increase of 22.2% from 1974. Major increases were in the Medicare and Medicaid programs. State and local governments spend considerably less than the federal government: $16.1 billion. As in the past year, hospital care took the largest share of health care expenditures, $46.6 billion in 1974. Physicians services were second with $22.1 billion, compared with $19.6 billion previously.[2]

These are startling amounts. They are reason for concern. In the main streams, the increases are from many sources:

(a) Inflation (cost increases to health care providers); (b) New dollars for new programs—programs which Congress previously approved; (c) More patients served requiring more dollars of government expenditures. In ten years, Medicare/Medicaid patients served have almost doubled; (d) Compliance with government regulations; (e) Sicker patients as a result of utilization requirements and emphasis on outpatient services; (f) Increased demand for care; (g) Improved quality of care; (h) Greater expectations from public and patients; (i) Third party payment mechanism which reimburses on a deficit basis; (j) The energy crunch has reached the sick patient; and (k) Malpractice cost increases.

The increases need to be evaluated and expressed properly to the public. To express gross percentages in relationship to Gross National Product is misleading. It stirs the emotions of people. We must begin to define, clarify, explain the increases.

The public speaks its opinion through the Louis Harris polls. A recent one reflects:

A 70—20 percent majority gives hospitals in general good marks on the job they are doing in caring for patients. (Source: "The Hospital and the Consumer", Review, The Investor-owned Hospital Magazine. April, 1976, pp. 12–14.)

We would not concur with H.E.W. Secretary Weinberger in his testimony before the Subcommittee on June 12, 1975, during which he said:

"I firmly believe that the faulty design of medicare and medicaid is the principal culprit responsible for . . . inflation in health care cost . . . . (With) the guaranteed government payment of health care cost in virtually any amount submitted by the provider, and with normal market factors absent in the health care area, inflation was bound to happen, and it did.”

---

[2] *Hospital Digest* (see above reference).

This statement seems to express that hospitals spend carelessly and irresponsibly. (“. . . virtually any amount submitted by the provider . . . .”). This rhetoric serves no useful purpose other than confusing the American people. We do concur that retrospective reimbursement is unfair to hospitals. The current system of reimbursement (retrospective reimbursement) in your terminology is called “deficit spending”. Let me illustrate:

“Every federal and state health dollar for services rendered costs every non-medicare patient $.10–$.15. This is deficit spending as a result of retrospective reimbursement.”

At Welborn, as the result of “deficit spending” non-medicare/medicaid has paid:

Indiana’s voluntary prospective reimbursement system may have affected cost in our state. For example:

	Indiana hospital cost per patient-day	U.S. cost per patient-day	Percent increase (decrease(
Cost:			
Per patient-day:			
1960	$32.93	$32.23	+2.2
1974	95.43	113.21	−15.0
Per case:			
1960	250.27	244.95	+2.0
1974	744.35	883.04	−15.0

A voluntary prospective reimbursement system was implemented in 1960.

Patient-days	Fiscal year ending	Annual amount	Per patient stay	Per patient-day
105,540	June 30, 1972	$735,459	$6.97	$62.70
106,314	June 30, 1973	456,975	4.30	38.90
107,088	June 30, 1974	738,000	7.89	62.00
111,655	June 30, 1975	502,952	4.50	40.54
117,840	June 30, 1976	934,317	7.93	71.36
Total		3,367,703		

Indiana has a prospective reimbursement system. It considers hospital needs.

Indiana has 139 hospitals; 113 are community short-term hospitals; 26 are long-term or special hospitals.

	Indiana	United States
Inpatient-day cost	$95.43	$113.21
Outpatient visits per 1,000 population	865.7	893.8
Occupancy rate (percent)	77.5	75.6
Beds per 1,000 population	4.3	4.4
Length of patient stay (days)	7.8	7.8

Source: “Hospital Digest,” vol. 1, No. 1, published by Branch Advertising Productions, Inc., Indianapolis, Ind.

How has the economy affected Welborn? Let me illustrate.

A recent Hospital Purchasing Management Journal states, “Spending for hospital supplies increased by a whopping 25 percent in 1975.”

How did it affect Welborn Hospital? Here are a few examples:

Item description	Unit	Unit cost			Percent increase		Vendor
		1970–71	1974–75	1975–76	Last 5 yr	Last year	
Elastic bandage	Roll	$3.73		$6.39	79		General Medical.
1-in plain Nugauze packing		12.79		18.70	46		Do.
4-in plaster bandage		5.06		7.72	53		Do.
4x4 sterile Ray-tec sponges		60.11	$71.20	90.47	51	27	Do.
3cc syringe with needle	100 ea	6.28		7.29	16		Do.
1x3-in band-aid	do	1.31	1.76	2.03	55	15	Do.
A185H suture	Dozen	5.74	6.47	7.19	25	13	Do.
Surgical blades	150 ea	20.26	22.30	24.05	19	10	Do.
Surgeon's gloves	Pair	.34		.40	18		Do.
3M Steridrape	Box/10	18.95	22.25	26.92	42	21	Do.
S1100 5 percent dextrose solution.	Case/6L	4.17	5.44	6.27	50	15	McGaw Labs.
V1400 vein set	Case/50	24.00	32.30	37.24	55	15	Do.
16 Fr Foley catheter	Dozen	31.65	37.08	38.75	22	5	General Medical.
Urinary drainage bag	20 ea	38.95	42.89	51.76	33	21	Do.
Unital soap	Bag	14.90	22.60	22.60	52		Kohnstamm.
Rust sour	Keg	33.50	51.30	51.30	53		Do.
Modess pads (regular)	Case		25.54	24.52		−4	Johnson & Johnson.
1¾-in Moore prosthesis	Each	92.50	114.00	136.25	47	20	Zimmer Mfg.
Ken nail 135°, 3 slot	do	40.45	49.05	51.50	27	5	Do.
3½x6-in slot Jewett nail 135°.	do	28.50	39.10	41.35	45	6	Do.
Skin scrub tray	Case/20	21.65	28.16	31.74	47	13	Crocker Fels.
18x18 lap sponges	do	36.51	36.75	31.95	−13	−13	Johnson & Johnson.

A recent article published in the Hospital Purchasing Management Journal stated:

"Hospital purchasing may be the fastest growing activity in our economy. Hospitals presently spend ten times as much per bed on purchasing materials and supplies as they did 15 years ago. During this period, the general price level increased by somewhat less than 100 percent. Therefore, real purchases, adjusted for inflation, increased about five times. Thus, real hospital purchased product increased ten times as much as overall real national product.

"It seems to be only a matter of time before the typical hospital spends more on purchased material and services than it spends on payrolls. Clearly, the economics of hospital operation are changing in a revolutionary fashion.

"Solutions and x-ray film were subject to special cost pressures during 1975. The average price hospitals pay for solutions went up almost 20 percent and prices of some popular solutions went up as much as 30 percent. These price changes were largely independent of general economic conditions." [3]

Traditionally, payroll cost has consisted of 60–70 percent of hospital cost. If purchased materials and services cost more than payroll cost, it will revolutionize the hospital operation.

An interesting bit of current information from our files is that we just completed a survey or inventory of all equipment and building cost with a professional organization. As of June 30, 1975, our recorded historical cost was $19,064,252. This is the amount used for reimbursement. However, our reproduction cost (replacement) was $32,546,700. This is disturbing. If reimbursement for the future is based on cost, you can easily ascertain hospitals may be in serious difficulty.

Hospitals have a great deal of specialized equipment. I have not gone into an indepth evaluation comparing the cost. Here are a few items.

---

[3] *Hospital Purchasing Management,* Vol. 1, No. 1, May, 1976, pp. 5–7.

Item	Cost			Percent increase		
	1970–71	1974–75	1975–76	Last 5 yr	Year	Vendor
Lakeside Cart, model 311	$43		$58.50	36		General medical.
Blood pressure unit, No. 0061–0400 wall-mounted.	47		65.00	38		Do.
IBM typewriter	540	$605	650.00	20	7	IBM.
Electrosurgical unit (cauterizing and cutting through tissue).	1,195		1,875.00	57		
	1965–66	1975–76		Last 10 yr		
Patient bed, electric	$438	$850		94		

	Amount	Percent
Standard radiographic/fluoroscopy room:		
1960 (room B)	$18,059	
1966 (room C)	24,146	34
1971 (rrom D)	73,838	409
1976 (proposed room A)	101,820	[1] 564
Special procedure room, Radiology and/or cardiac catheterization:		
1960 (estimate)	$100,000	
1971 (present special procedure room)	179,254	
1976 (accurate estimate)	300,000–600,000	
Portable bedside unit:		
1960 (picker)	3,218	
1971	8,082	
1976	17,000	[2] 528
Mammography unit:		
1973 (our existing senoegraphe)	$17,000	
1976	26,000	[3] 53
X-ray tube:		
1956	590	
1962	715	21
1971	3,000	500
1976	3,900	[4] 661

[1] Or 35 percent per year.
[2] Or 31 percent per year.
[3] Or 18 percent per year.
[4] Or 33 percent per year.

OTHER COST INCREASES

On March 9, 1975, and again on February 29, 1976, the FCC permitted AT&T to raise interstate long distance rates. In less than a year, the cost of a typical long distance conversation of seven minutes, which travels 71 to 925 miles, has increased an average of 25 percent. Call cost for shorter distances have averaged a 73 percent increase.[4]

Insurance Cost.

Year	Cost	Percent
1974	$81,884	
1975	89,622	
1976	228,336	280
Drug cost:		
1974	256,077	
1975	268,357	
1976	389,211	50

ENERGY CRUNCH

The energy crunch has reached the sick patient. Today at Welborn, it costs $3.00 for every patient day, and on the average, $27.00 for each hospital stay for natural gas and electricity. We envision an increase of two to three times our present utility cost over the next five to ten years. In addition, we can anticipate an enormous capital outlay for conversion to an alternate source of energy.

---

[4] "Communications", published by Extension Telephone Company. May–July, 1976.

Our hospital has been asked to drastically reduce (60%) our natural gas consumption by November, 1976. The announcements have vacillated from no curtailment to a 60 percent reduction. Quantity entitlement announcements are received based on availability.

The capital expenditures will be great. The operating cost, astronomical. The only method of paying for the new systems will be through increased charges to patients. The energy crunch and its impact upon hospital cost is an illustrative example of economy pressures outside hospital control. This year it is energy; last year, malpractice; the previous year, food; next year, life safety codes; in the future, national health insurance and a continual flow of government regulations—all of which cost enormous amounts of money.

The following data reflects the trend in cost increases:

COST OF NATURAL GAS AT WELBORN

	Apr. 1–Mar. 31		Cost per thousand cubic feet	Percent increase
	Thousand cubic feet	Cost		
1972–73	163,242.5	$93,418	0.572	4.4
1973–74	157,306.9	93,872	.597	16.8
1974–75	137,433.0	95,767	.697	13.5
1975–76	163,965.8	129,632	.791	17.2
1976–77 (Apr.–May)	23,588.4	21,869	.927	

COST OF ELECTRICITY AT WELBORN

	Apr. 1–Mar. 31		Cost per kilowatt hour	Percent increase
	Kilowatt hour	Cost		
1972–73	10,424,933	$147,645	0.0142	
1973–74	10,735,048	150,030	.0140	
1974–75	11,009,672	161,933	.0147	
1975–76	11,547,365	200,999	.0174	18.4
1976–77 (Apr.–May)	1,815,885	34,179	.0188	8.0

To project for the future in the way of operating cost at present prices, we envision:

	Present cost	100 percent fuel oil	100 percent electricity	100 percent coal	Solar energy
Natural gas	$132,600				(1)
Fuel oil		$413,700			(1)
Electricity	215,000	215,700	$786,400		(1)
Coal					(1)
Total	347,300	647,000	687,400	524,900	
Capital outlay		75,000	500,000	1,000,000	(1)
Per patient day	2.95	5.39	5.73	4.37	(1)
Per hospital stay	26.50	48.50	51.55	3.937	(1)

[1] Too expensive to estimate.

The amounts do not take into consideration capital outlay for energy recovery or reduction in operating cost for such a program.

The local hospital ends up bearing the responsibility in explaining to the public the reasons for the accelerating hospital cost (NOT the local supplier of natural gas, NOT the pipeline company, NOT the Federal Power Commission, NOT the State Public Utility Commission, NOR the hospital associations).

Just recently, I have read where the Alaskan pipeline is a bureaucratic disaster. The postal service is inefficient. The present Medicare/Medicaid method of reimbursement needs to be abandoned and a new method devised. Welfare programs are considered in shambles. The tax system, antiquated. If these are facts of our time, then we should use them as lessons for future programming in health care.

Congress should consider as top priority a complete reorganization of existing health programs before any future programs are added. Short-term cost control or a cap on hospital reimbursement is not the solution. It seems government is intent on reducing and controlling the rate of increase in hospital payments under Medicare and Medicaid. A cap on reimbursement only reduces cash flow to hospitals and does not address questions of the financial requirements of hospitals, state level prospective rate review programs, and inadequate Medicare/Medicaid payments. A cap on reimbursement only reduces cash flow to hospitals and does not address the national economic problem outlined in these comments. Hospitals have little or no control over the prices charged for equipment and supplies or the energy crunch, or the other changes in our economy.

Recently Director Michael H. Moskow of the Council on Wages and Price Stabilization reported to the press, "It is a national economic problem, not just a health care problem."

The American Hospital Association recently called for a thorough analysis of cost in a statement submitted to the Democrat Platform Committee. They said, "Because there is widespread misunderstanding of why health care costs ars rising, increased health care cost must be examined in light of the improved health of the American people." The AHA pointed out that H.E.W. statistics confirm that our health care system has produced a steady decline in the national mortality rate in the past several decades.

William E. Simon, U.S. Seccretary of the Treasury, seems also to indicate that it is a national economic problem, not just a health care problem, when he told the Trit-State Hospital Assembly's opening session recently that the "burden of paying the government's bills has become so heavy for taxpayers that many are now in open rebellion".

It is quite obvious that we have an economic problem that is contributing to the health care cost. To separate out just the health care industry and reduce cash flow or reimbursement through a cap on national programs will not solve the problem.

The information going to the public is misleading. It is time we join hands in community education to evaluate increases in cost and express them properly to the public. To express programs in billions and relationship to the Gross National Product is unfair to our public. It stirs the emotions of people. We must begin to clarify, define, and explain hospital cost.

To hold the health care industry totally liable for increased health care cost is like standing in the middle of a raging forest fire blowing out a match.

The health care industry is not the major culprit for inflation, nor is Medicare and Medicaid. We have a major economic problem that is the culprit. We must solve it together, and not expect the health industry to solve the problem. To single out the health industry and reduce reimbursement through a cap or cost controls will frustrate, stifle, choke, and bring the health care systems to their knees. You and I do not want to impair our health system. Therefore, we must get on with some positive programs before another step is taken to control or add new programs or even think of a National Health Insurance program, such as:

1. A complete reorganization of all health care programs prior to the implementation of a single new program.
2. The establishment of voluntary prospective reimbursement programs based on financial NEED.
3. Programs for community health education.

Mr. Rostenkowski. Thank you, Mr. Gent.

Any questions?

Mr. Cotter. I have none.

Mrs. Keys. I have none.

Mr. Rostenkowski. Thank you very much.

Next we have Mr. Hofrichter.

Mr. Hofrichter. Thank you.

Mr. Rostenkowski. Mr. Hofrichter, your entire statement will be placed in the record.

STATEMENT OF FREDERICK L. HOFRICHTER, ASSOCIATE FOR LEGISLATION, INTERRELIGIOUS COALITION ON HEALTH CARE

Mr. HOFRICHTER. Thank you, Mr. Chairman.

I am Frederick L. Hofrichter, the associate for legislation of the Office for Church in Society of the United Church of Christ and am presenting this testimony on behalf of the Interreligious Coalition on Health Care, which had its origins in 1971, consists of representatives from major religious denominations, Jewish, Protestant, and Catholic. It provides an essential base from which the denominations, drawing together upon each other's expertise, can jointly and intelligently impact the future direction of health care reform.

I might say that while we have associated with the denominations many health care providers, the coalition personnel are predominantly drawn from the advocacy offices of the denominations.

Each of the organizations which the coalition seeks to represent have their own policy statements on health care. We request that these be included along with this testimony in the record of this hearing. In presenting this testimony I do not purport to speak for all the groups as a unanimous body. We do hope that the committee will note, however, the remarkable consistency in their various policy statements herein submitted.

The coalition compliments Representative Duncan and Senator Talmadge for their interest and concern with health delivery in the United States and with their honest attempts to deal with some of the most pressing problems. We believe that the introduction of H.R. 13080 expresses this deep-rooted concern.

When Senator Talmadge submitted the bill in the Senate, he stated that we just cannot go on this way.

Health care costs continue to rise at a phenomenal rate, a rate much higher than the overall rate of inflation. This year we will spend an estimated $130 billion on health care. The Congressional Budget Office projects that under current policy total health care spending will reach $250 billion by 1981.

The health care system/industry as it now exists has the undeniable capacity to easily absorb all the dollars that are available. Unfortunately it does not have the same capacity to deliver quality health care to all.

Yes, "It is time—in fact, past time," as Senator Talmadge has said, "to put our house in order." How can this be done?

The first thing that must be clearly realized is that there is much more wrong with the present system than escalating costs. I am sure that the members of this committee have heard these problems mentioned before—geographic maldistribution, unnecessary surgery and testing resulting in poor quality care, duplication of facilities, and poor utilization of personnel.

We trust that the committee realizes the interdependence of all of these, how each one affects and perpetuates the other and how they all together facilitate the escalation in health care costs—all I must add, to the detriment and pain of too many of our people who fail to receive the quality medical care that should be theirs by right.

Throughout today we have had a number of people before this committee presenting a great deal of expertise on costing and reimbursement in health care. Yet this cannot be solved by piecemeal and fragmented solutions.

To some extent it reminds me of a group of Olympic-quality athletes attempting to capture a greased pig, each with one hand tied behind his back. Because the fragmentation of payment systems is so great, we cannot deal with the total escalation of costs, which has been reported a number of times today where Medicare and Medicaid do not cover costs. They are passed on to other third-party payers. Where the other third-party payers say we are not going to pay this cost, it gets passed on to the individual self-payment.

So on and on, around it goes. The only way, we feel, that we can deal with the health system as it exists—to curtail costs, to make spending accountable, to solve the maldistribution problem, both geographic and specialty and to provide the stimulus for reorganization of the delivery system is through the enactment of a universal, mandatory and comprehensive National Health Care program.

So long as we continue to categorize people into sub-groups using all types of criteria except need; so long as we continue to perpetuate a multifaceted payment system with no accountability; so long as we continue to perpetuate the myth that the free market in health care exists and works—then all we can expect to have is continued inflation in health costs, more duplication and inefficient practice and more suffering.

Yes, we cannot afford to go on. Yes, we must put our house in order—by enacting a universal and comprehensive National Health Care program. We urge you, the committee members, to work toward that goal. We sincerely hope that H.R. 13080 is not seen as an end in itself, but is instead a step on the road toward the enactment of such a plan. It is long overdue, it is necessary and the people want it.

I will not speak directly to H.R. 13080.

This provides a mechanism, a model by which a comprehensive system can be dealt with. The first sections of the bill dealing with the consolidation of Medical Services Administration, Bureau of Health Insurance, Bureau of Quality Assurance and the Office of Nursing Home Affiairs into a single administrative unit, the Health Care Financing Administration under the direction of an assistant secretary, is essential. It is useful. It will reduce the number of one-handed people going after the greased pig.

Section 4 in the bill requires improvements in four areas of medicaid administration. We strongly welcome the proposal to establish a formal uniform Federal performance standards index for State medicaid programs and the tying of these standards to Federal matching toward administrative costs.

We go on and on. One of the things in here is quality control. Quality control is a multifaceted thing, two facets. One is quality control of administration. The other is working with PSRO's and quality of services.

Quality control of administration is absolutely necessary, but quality of services is also necessary, also has an effect on long-term costs. Effectively quality control programs can help to reduce the problems which a number of people have brought up with malpractice insurance rates. It can also reduce the problems caused by people having to go back into health care systems, because that was tried the first time and didn't work.

Claims processing. The speeding up of claims processing can be very helpful. It has been brought up a number of times here that providers do have problems with cash flow and do need to get their claims paid on time. This reduction of the need to go out and borrow money for cash flow can reduce our problems.

We have a number of questions—and I think I am going to just go over the questions and leave you all to answer them.

Section 10 class hospitals by size and type only. How about the geographic location of the hospital? How about grouping hospitals on the basis of sponsorship, whether they be private nonprofits, whether they be proprietaries?

You might come up with some interesting statistics that way. We go along with a number of the other people before the committee today in saying that reimbursement must be on a prospective basis. Historical reimbursement has contributed as much to inflation of costs as anything else.

There are a number of things which are not in the bill which was originally considered and which I think might be considered further.

It was quite obvious that broad inefficiencies have characterized the practices of some intermediaries and carriers under the medicare system. Your original intent, if I am correct, was to establish an objective, competitive selection process under which the most qualified intermediaries in terms of efficiency and accountability would receive contracts. Such a process we believe to be essential. Why not include it in the legislation?

Also why was the provision by which carriers in intermediaries would be expanded or consolidated whenever necessary to provide efficiency left out?

Finally, we have a serious problem with the inclusion of productivity incentives whereby carriers whose full costs were less than the negotiated fixed fee would realize an increased revenue. Might this not be carrying incentive techniques a little bit too far?

Originally, some intent which was talked about was to promote the responsibility for administering medicare part A and part B under a single agency instead of the present dual arrangement. Why was this not finally included?

We support the proposal to allow reimbursement for costs associated with the closing or conversion of underutilized hospital facilities and services. One question, however: Does this offer the opportunity of abuse? What prioritizing would be used?

The bill calls for setting up a board to facilitate this section. Is it necessary? Might that not be duplicative? Why not set it with the health systems agencies?

In conclusion, we would like to congratulate the committee on your efforts to make improvements in the way of medicare and medicaid handling. Such reforms are vital for the success of these programs as well as any future national health insurance program—a goal we hope this committee is working toward.

Thank you.

[The prepared statement follows:]

Statement of Frederick L. Hofrichter

Mr. Chairman and members of the Committee, my name is Frederick L. Hofrichter. I am Associate for Legislation of the Office for Church in Society—United Church of Christ and am presenting this testimony on behalf of the Interreligious Coalition on Health Care. The Interreligious Coalition, which had its origins in 1971, consists of representatives from major religious denominations—Jewish, Protestant and Catholic. It provides an essential base from which the denominations, drawing upon each other's expertise can jointly and intelligently impact the future direction of health care reform.

Each of the organizations which the Coalition seeks to represent have their own individual policy statements on health care. We request that these be included along with this testimony in the record of this hearing. In presenting this testimony, I do not purport to speak for all the groups as a unanimous body. We do hope that the Committee will note, however, the remarkable consistency in their various policy statements herein submitted.

The Coalition has been very active in the debate so far and has submitted other testimony before this and other committees in Congress. In May 1975, it sponsored a House and Senate staff briefing session on "The Make or Break issues on National Health Care", a session which was remarkably well attended. The Coalition has also developed informative and factual materials on health care which have been widely distributed. This educational role, has in fact, been one of the cornerstones of the Coalition's efforts. Part of its educational role is to stress and promote the moral and ethical aspects which must be considered in any health reform deliberations.

The Coalition compliments Representative Duncan and Senator Talmadge for their interest and concern with health delivery in the United States and with their honest attempts to deal with some of the most pressing problems. We believe that the introduction of H.R. 13080 expresses this deep rooted concern. Senator Talmadge who introduced similar legislation in the Senate, is correct when he states that the health care system must be made more efficient and economical. The Senator is correct when he states that we "just cannot go on this way." Health costs continue to rise at a phenomenal rate, a rate much higher than the overall rate of inflation. This year we will spend an estimated $130 billion on health care. The Congressional Budget Office projects that, under current policy, total health care spending will reach $250 billion by 1981. The health care system/industry as it now exists has the undeniable capacity to easily absorb all the dollars that are available. Unfortunately it does not have the same capacity to deliver quality health care to all. Yes, "it is time—in fact, past time" as Senator Talmadge has said, "to put our house in order." How can this be done? The first thing that must be clearly realized is that there is much more wrong with the present system than escalating costs. I am sure that the members of this committee have heard these problems mentioned before—geographic maldistribution, unnecessary surgery and testing resulting in poor quality care, duplication of facilities and poor utilization of personnel. We trust that the committee realizes the inter-dependence of all of these, how each one effects and perpetuates the other and how they all together facilitate the escalation in health care costs—all I must add, to the detriment and pain of too many of our people who fail to receive the quality medical care that should be theirs by right.

These problems, which make up the total health care crisis are complex. Yet they will not be solved by piecemeal and fragmented solutions. HR 13080 is in itself a good piece of legislation and we commend Representative Duncan for introducing it. But it only deals with part of the problem. The Coalition feels that there is only one effective way to deal with the health system as it exists—to curtail costs, to make spending accountable, to solve the maldistribution problem, both geographic and specialty and to provide the stimulus for reorganization of the delivery system is through the enactment of a universal, mandatory and comprehensive national health care program. So long as we continue to categorize people into subgroups using all types of criteria except need; so long as we continue to perpetuate a multifaceted payment system with no accountability; so long as we continue to perpetuate the myth that the free market in health care exists and works—then all we can expect to have is continued inflation in health costs, more duplication and inefficient practice and more suffering. Yes, we cannot afford to go on, yes, we must put our house in order—by enacting a universal and comprehensive national health care program. We urge you, the committee members, to work toward that goal. We sincerely hope that H.R. 13080 is not seen as an end in itself but is instead a step on the road towards the enactment of such a plan. It is long overdue, it is necessary and the people want it.

I will now speak directly to H.R. 13080.

ADMINISTRATIVE REFORMS

The consolidation of the Medical Services Administration, the Bureau of Health Insurance, the Bureau of Quality Assurance and the office of Nursing Home Affairs into a single administrative unit—the Health Care Financing Administration under the direction of an Assistant Secretary is essential to promote uniform policy making and administration and to enhance accountability. We enthusiastically support the bringing together of the Federal Government's largest financing programs (Medicare and Medicaid with its two main regulatory authorities (the office of Nursing and Home Affairs and the Bureau of Quality Assurance). For years, especially since the mid 1960's, policy could not be developed in a coherent and uniform way. This was frustrating for all parties involved—the agencies, the states, the providers and the program recipients. Too often the four agencies have issued conflicting regulation on the same subject. We find this consolidation a necessary preparatory action towards any development of any national health care program. Its implementation should be closely evaluated and mentioned especially in terms of how it relates to other health programs within the federal bureaucracy which continue to remain separate.

The sections dealing with the prevention of fraud and abuse are well developed and much needed. Their effectiveness, however, will depend on how they are implemented.

Section 4 in the bill requires improvements in four areas of medicaid administration. We strongly welcome the proposal to establish a formal uniform Federal performance standards index for state medicaid programs and the tying of these standards to Federal matching toward administrative costs.

1. Eligibility—The bill would require that medicaid eligibility under Titles 1, IV–A, X and XVI, except for the disabled be determined within 30 days of the application. For disabled persons the limit would be 60 days. Redeterminations would be necessary at least every six months. Any alteration in the person's eligibility status would have to be processed within 30 days.

2. Quality control. The medicaid quality control requirements presently in effect would be modified in an attempt to improve the accuracy of medicaid eligibility determinations. The maximum tolerance level for errors would be equal to the 50th percentile of rates reported by the states for the period October 1, 1975 to March 1, 1976. This tolerance level, while seeking to build on state experience, is based, on an arbitrary standard of state error rates. For example, if all state error rates were clustered around a certain mean, the median percent would fall in the middle. Under the bills' requirement, those states with rates even a minute fraction above this median would be out of compliance. On the other hand, should there be wide variation among state error rates the median might not reflect many states. The 50th percentile is thereby quite arbitrary. This is one area that might be modified, e.g., the consideration of a range for normative error rate.

The requirement that the states' error rates be published may arouse some displeasure, but it does not guarantee that a state which is out of compliance will make any substantive response. Follow up is needed.

We have a few basic concerns in regard to the sections on eligibility and quality control. One is the implied meaning of quality control. Quality control is much more than controlling the accuracy of eligibility determinations and redeterminations. The concept of quality control must be extended to incorporate the appropriateness and effectiveness of the actual service delivered to a patient. Quality control is not synonymous with cost control, but is related to long-term costs by preventing needs for retreatment and correction of errors. While these two sections are to a large extent consistent with one another, they do contain the potential for inefficiency. As we all know, eligibility requirements for assistance are highly complex and difficult to understand. Imposing strict time limits on eligibility determination may not foster efficient and accurate determination—that is, unless the criteria for eligibility are changed. This complex eligibility problem is a direct outgrowth of any system that purposely categorizes people into different subgroups in order to qualify for services. It is aggravated by the fact that health need is not the only nor necessarily the primary criteria in determining eligibility. A Universal N–H–1 which would treat all people equally under one system is the most effective way to finally solve this problem.

3. Claims Processing—Many states already screen claims for these requirements, especially those states which employ the Medicaid Management Information System (MMIS).

We welcome the requirement of periodic preparation and submission of reports concerning eligibility, claims processing, provider participation and service utilization (by age, sex, race, etc.). It addresses a major problem of insufficient information about the Medicaid programs. One question, however—What guarantees are there that this information will ever be put to any kind of use?

The above requirements, penalties and incentives raise several issues which need to be addressed.

1. The objective of these requirements is to encourage efficiency in program management and administration. The bill requires the performance of a number of processes. Yet we are not too sure that all these processes, many which seem just too cosmetic would do much to achieve efficiency, e.g., the submission of quarterly reports, the specification of tolerance levels, etc.

2. Experience tells us that the Department of Health Education and Welfare has not monitored state compliance efficiently and consistently over time. Will it do it this time? We hope that the involvement of GAO, in partnership with DHEW will help to solve this problem. At least it gives the legislative branch the opportunity to work directly with the executive branch in program evaluation.

3. Each set of requirements in the bill is accompanied by financial incentives to assume appropriate compliance. The incentives are both positive and negative. In light of the fiscal problems in many states, and the current overall economic situation, are penalties the most effective mechanisms to use? To what extent may they give rise to program cutbacks which may directly harm program recipients?

4. The ability to comply with the Federal requirements varies among states. Total compliance by many states may not be feasible at the current time. Compliance will require additional funds. However, while the bill calls for increased technical assistance, no additional federal dollars have been allocated for this purpose. Can the states afford the increased costs? Also what is there in the bill to increase the Federal and Regional staffs available to Medicaid so that the technical assistance can be adequately provided?

PROVIDER REIMBURSEMENT

This part of the bill attempts to establish a reimbursement system for hospitals which would reward hospitals whose comparable routine operating costs are less than the average and penalize hospitals whose routine operating costs are above the average. Such a reform should help curtail costs; the legislation, however, leaves many unanswered questions.

1. Section 10 classifies hospitals by size and type only. Should not consideration be given to the geographic location of the hospital? Should not hospitals be grouped on the basis of sponsorship?

2. We agree that performance based reimbursement is the key to dampening inflation. If rates are to be determined on the basis of historical costs, however, an institution that succeeds in reducing its expenses can be assigned this new level as a base year, in other words, facilities could be penalized for their efficiency. Also basing reimbursement rates on historical costs, makes the dubious assumption that all institutions were running efficiently at the outset of the program.

3. The scope of the proposed reforms is limited since the system would exclude hospital costs related to capital, medical personnel, education, training and energy?

4. For hospitals whose operating costs are way above the average there would be no incentive to do anything except get down to the maximum reimbursement allowed—20% above the target. Should not the goal be to provide incentives for the majority of hospitals to spend at or below the target rate? If these rates are too loosely applied the bill may provide incentives for hospitals to spend right up to the allowable rate. This has been happening in New York State.

5. We have some question concerning the use of geographic wage rates in determining the target rate for each hospital. Who would determine what the general wage levels were? Would it be done on occupational basis or on an industry basis? What is the role of unions?

PHYSICIAN REIMBURSEMENT

We fully support any attempts at encouraging acceptance of "assignments" of Medicare reasonable charges by physicians. We have some comments regarding the incentives in HR 13080. We agree on the desirability to cut down on unnecessary red tape, we wonder if it is realistic to think that physician reimbursement within 5 days is feasible. The administrative cost saving allowance of $1 for each patient sounds somewhat ironic. It would undoubtedly add to the paperwork and red tape. If the goal of this allowance is to encourage physician participation, why not just raise the Medicare fee levels by this amount?

The attempts of HR 13080 in the area of physician reimbursement sounds a little cosmetic. It makes no basic changes in the way Medicare pays for physician services. Should not this be the time to completely eliminate from the program any physician who refuses to accept the Medicare fee as payment-in-full? Should not this be the time to experiment with different methods of reimbursement, such as capitation?

It is regretful that the drafters of HR 13080 retreated from including in the final bill many recommendations which they were originally considering. For example:

1. It is quite obvious that broad inefficiencies have characterized the practices of intermediaries and carriers under the Medicare program. Your original intent if we are correct, was to establish an objective, competitive, selection process under which the most qualified intermediaries in terms of efficiency and accountability, would receive the contract. Such a process we believe to be essential. Yet, why has it not been incorporated in HR 13080?

Also, why was the provision whereby carrier and intermediary areas would be expanded or consolidated whenever necessary to promote efficiency left out?

Finally, we have a serious problem with the inclusion of "productivity incentives" whereby carriers whose actual costs were less than the negotiated fixed fee could realize increased revenues. Is this not carrying incentive techniques a little too far?

2. Originally your intent was to promote the consolidation of responsibility for administering Medicare Part A and Part B under a single agent instead of the present uneconomical dual arrangement. Why was this not finally included in the bill?

We support the proposal to allow reimbursement for costs associated with the closing or conversion of underutilized hospital facilities and services. One question, however—does it offer the opportunity of abuse? What prioritizing procedure would be used? The bill calls for the setting up of a Hospital Transitional Allowance Board to facilitate this section. Is this necessary? Is it not duplicative? The correct place to make these decisions, concerning the allocation of limited public monies to health facilities, is the appropriate health systems agencies which are now being set up. These have both the expertise and accountability that's desired.

Our congratulations on your efforts to make improvements in the way of Medicare and Medicaid. Such reforms are vital for the success of these programs, as well as any future national health insurance program—a goal we hope this committee is working toward.

Mr. ROSTENKOWSKI. Thank you very much.

Any questions?

Thank you very much.

Mr. Edwards?

STATEMENT OF ARCH B. EDWARDS, McKINSEY & CO., INC., WASHINGTON, D.C.

Mr. EDWARDS. I am Arch Edwards. I live in Washington, D.C. I am a director of the international management consulting firm, McKinsey & Co., Inc., and I am responsible for my firm's practice with health care organizations.

The concern of the subcommittee today is how to bring the rate of increase in hospital care costs incurred under medicare down to affordable levels. Containing the rate of increase in health care cost generally, and hospital costs in particular, is the overriding issue with respect to health care now. However, if progress is to be made, it is important that we all agree on the reasons for the unacceptably high rates of increase in hospital care costs that the country has experienced over the past decade or more.

In addition to general price inflation, the immediate causes, in approximate order of importance, are: (1) increased application of capital- and materials-intensive treatment procedures; (2) substantial duplication of high-cost facilities; (3) increases in hospital staffing levels and wages rates; and (4) increased admissions and total hospital days incurred per 1,000 of population.

These immediate contributors to hospital care expenditure increases, however, are really only symptoms of the underlying causes. These underlying causes are basically fourfold:

(1) Since the demand for health services is essentially unlimited, as one threat to a population's health is eliminated or brought under control, another comes forward to demand attention.

(2) The potential for medical science to evolve new, more sophisticated, and more costly care programs is also essentially unlimited.

(3) Since the 1960's, with the advent of medicare and medicaid and with continuing expansion of private insurance programs, financing for health care across the American population has been plentiful.

(4) The structure of the American health care system provides no meaningful check on the volume of services demanded and provided, and no real incentive for efficiency in the provision of those services.

Few would say that further increases in health and hospital care expenditures can or should be avoided. However, many people now agree that steps need to be taken to slow the current rate of expenditure growth for two reasons. The first is that the disproportionate growth being experienced is siphoning resources from the society's other important needs.

Secondly, and perhaps even more fundamentally, questions are now being raised about the real contribution to the health of the Nation of these increases in expenditures for medical services. But despite this growing concern, the underlying problems cited above mean that costs will rise inexorably unless a system of management controls and structural changes is developed to contain them.

I recognize that the subcommittee's immediate concern is to control the costs of hospital care rendered to medicare and medicaid beneficiaries. However, the plain fact of the matter is that in the longer term hospital care costs for these citizens cannot be controlled—in other than a discriminatory manner—without controlling the costs of hospital care for all. Thus, in the remainder of my testimony I shall talk about the requirements for an effective hospital care cost containment program for all Americans.

No single action will bring hospital care costs growth under reasonable control. Rather, a range of programs is required to bring the rate of increase in hospital—and all health care—costs down to affordable levels while continuing to meet the people's essential needs for quality health care. In order to deal with the underlying causes of hospital expenditure increases, these control programs should address both the quantity of money and people that will be made available to provide health care, and the way in which that care is provided. Most importantly, the elements of a successful cost containment program include:

First, significant reductions in the growth in the number of physicians and other health care professionals, relative to the Nation's population, that we have experienced in the past and will continue to experience under current manpower training programs.

Second, effective processes for allocating health care programs and facilities across regional areas.

Third, an effective approach—substantially different from the current PSRO program—for controlling admissions, length of stay, and inhospital service utilization.

Fourth, much greater emphasis on nonmedical programs for improving health—primarily through enhancement of the environment and encouragement of less self-destructive lifestyles.

Fifth, prospective reimbursement of hospitals based on the concept of establishing limitations on the total volume of services that can be provided by individual institutions or groups of institutions.

I want to emphasize that prospective reimbursement, upon which the subcommittee is concentrating, while very important, is only one element of an overall cost containment program. Without action on the other fronts, it is unlikely that the objective sought by the proposed legislation will be achieved. Having said that, let me, also, concentrate on the requirements for a successful prospective reimbursement program. Not only is this the subject of the day, but I also believe that a prospective reimbursement system, rightly designed, is the key to a cost containment program.

To be effective in helping control the rate of increase in expenditures for hospital care, a prospective reimbursement system must do more than establish the payment rates for services to be rendered by hospitals. Rather, the prospective reimbursement system must also establish an absolute limit on the volume of service than can be provided by each institution during the prospective budget period. This service volume limitation should ultimately be expressed as a dollar budget ceiling, subject to carefully controlled retrospective adjustment for specific occurrences outside the control of the hospitals' budget management. However, the dollar budget ceiling should be established based on targets for physical measures of hospital service utilization, such as the number of discharges for which reimbursement will be provided during the coming budget period.

Without limitations on the volume of services that can be provided—as opposed to specification of payment rates for units of service—the structure of the American health care system insures that hospital care costs will continue to rise. This is so because technology, facilities, and program expansion, and service utilization are the driving forces behind hospital cost increase. Each of these grows on a commitment to unlimited service volume. Physicians—who determine the type and volume of care that will be provided—simply cannot be expected consistently to guard the purse of the Government or other third-party payers when their training and rewards are based on maximizing service. With humanely established service volume limitations, however, physicians can be depended upon to set sound priorities for patient treatment.

With a prospective budgeting process in place that includes establishment of firm budget ceilings, a sound system of utilization controls can help physicians and hospital managers live within their budgets. Thus, utilization controls play a complementary role in an overall cost containment program. Such controls likely can never be sufficiently strong and consistently applied to eliminate the need for service volume limitations.

Additionally, the service volume limitation for a hospital provides the critical link between prospective reimbursement and the regional health planning process. The budget ceiling for a hospital should be developed based on the target volume of activity for the specific services to be provided by the hospital as established in a regional health plan. Following this approach, the reimbursement agency can serve to help insure implementation of the regional plan.

About a year ago my associates and I surveyed 20 or so prospective reimbursement programs in operation in this country. None included provision for establishing service volume limitations; and none had been markedly successful in containing the rate of growth in hospital care expenditures. Service volume limitations are, however, an integral part of the National Health Service in the United Kingdom. As we all observe, the NHS has serious problems. However, these problems are demonstrably due to a simple lack of adequate resources to fund essential care, and to the ways the service volume limitations are set. The fact of the matter is that by most measures the population of the United Kingdom is as well cared for as, and is healthier than, our own. Moreover, United Kingdom per capita expenditures are about 30 percent of our own, and have been growing at a significantly slower rate.

Setting service volume limitations means rationing health care. However, in this country it does not have to mean failure to provide essential care to those who need it. Rather, it means developing, over time, a changed way of thinking about who needs what care. This changed way of thinking will only follow a change in the structure of the health care system that introduces the realization that resources for the provision of care are, indeed, limited.

Prospective reimbursement, based on the concept of service volume limitations, provides the way of bringing about this new way of thinking. The demographic and epidemiological data and techniques are available to provide the basis for developing such an approach. With sensitive implementation, this fundamental change can be made without jeopardizing the quality of American health care.

In my written statement I go on to provide features of the operating system. I will leave that to your reading.

I want to make two comments on the legislation that has been proposed.

First, in calling for the discrimination among the types of hospital costs that will be subject to prospective reimbursement the establishment of peer groups at hospitals to set standards for those costs, we think these important features are essential to an effective reimbursement system. Obviously from my testimony I see a shortcoming in the legislation in that it does not include a provision for establishing service volume limitations.

Second, I think any effective legislation is going to have to include steps for moving from implementation of prospective reimbursement for Federal beneficiaries to implementation of such a system for the entire population?

I would be glad to answer any questions.

[The prepared statement follows:]

STATEMENT OF ARCH B. EDWARDS, WASHINGTON, D.C.

MAKING PROSPECTIVE REIMBURSEMENT WORK

My name is Arch B. Edwards. I live in Washington, D.C. I am a Director of the international management consulting firm, McKinsey and Company, Inc., and I am responsible for my firm's practice with health care organizations.

The concern of the subcommittee today is how to bring the rate of increase in hospital care costs incurred under medicare down to affordable levels. Containing the rate of increase in health care cost generally, and hospital costs in particular, is the overriding issue with respect to health care now. However, if progress is to be made it is important that we all agree on the reasons for the unacceptably high rates of increase in hospital care costs that the country has experienced over the past decade or more. In addition to general price inflation, the immediate causes, in approximate order of importance, are: (1) increased application of capital—and materials—intensive treatment procedures; (2) substantial duplication of high-cost facilities, (3) increases in hospital staffing levels and wage rates; and (4) increased admissions and total hospital days incurred per 1,000 of population.

These immediate contributors to hospital care expenditure increases, however, are really only symptoms of the underlying causes. These underlying causes are basically four-fold:

1. Since the demand for health services is essentially unlimited, as one threat to a population's health is eliminated or brought under control another comes forward to demand attention.
2. The potential for medical science to evolve new, more sophisticated, and more costly care programs is also essentially unlimited
3. Since the 1960's, with the advent of medicare and medicaid and with continuing expansion of private insurance programs, financing for health care across the American population has been plentiful
4. The structure of the American health care system provides no meaningful check on the volume of services demanded and provided, and no real incentive for efficiency in the provision of those services.

Few would say that further increases in health and hospital care expenditures can or should be avoided. However, many people now agree that steps need to be taken to slow the current rate of expenditure growth for two reasons. The first is that the disproportionate growth being experienced is syphoning resources from the society's other important needs. Secondly, and perhaps even more fundamentally, questions are now being raised about the real contribution to the health of the nation of these increases in expenditures for medical services. But despite this growing concern, the underlying problems cited aobve mean that costs will rise inexorably unless a system of management controls and structural changes is developed to contain them.

I recognize that the subcommittee's immediate concern is to control the costs of hospital care rendered to medicare and medicaid beneficiaries. However, the plain fact of the matter is that in the longer term hospital care costs for these citizens cannot be controlled—in other than a discriminatory manner—without controlling the costs of hospital care for all. Thus, in the remainder of my testimony I shall talk about the requirements for an effective hospital care cost containment program for all Americans.

A COST CONTAINMENT PROGRAM

No single action will bring hospital care costs growth under reasonable control. Rather, a range of programs is required to bring the rate of increase in hospital—and all health care—costs down to affordable levels while continuing to meet the people's essential needs for quality health care. In order to deal with the underlying causes of hospital expenditure increases, these control programs should address both the quantity of money and people that will be made available to provide health care, and the way in which that care is provided. Most importantly, the elements of a successful cost containment program include:

1. Significant reductions in the growth in the number of physicians and other health care professionals, relative to the nation's population, that we have experienced in the past and will continue to experience under current manpower training programs
2. Effective processes for allocating health care programs and facilities across regional areas
3. An effective approach—substantially different from the current PSRO program—for controlling admissions, length of stay, and in-hospital service utilization
4. Much greater emphasis on nonmedical programs for improving health—primarily through enhancement of the environment and encouragement of less self-destructive life styles
5. Prospective reimbursement of hospitals based on the concept of establishing limitations on the total volume of services that can be provided by individual institutions or groups of institutions.

I want to emphasize that prospective reimbursement, upon which the subcommittee is concentrating, while very important is only one element of an overall cost containment program. Without action on the other fronts, it is unlikely that the objective sought by the proposed legislation will be achieved. Having said that, let me, also, concentrate on the requirements for a successful prospective reimbursement program. Not only is this the subject of the day, but I also believe that a prospective reimbursement system, rightly designed, is the key to a cost containment program.

PROSPECTIVE REIMBURSEMENT APPROACH

To be effective in helping control the rate of increase in expenditures for hospital care, a prospective reimbursement system must do more than establish the payment rates for services to be rendered by hospitals. Rather, the prospective reimbursement system must also establish an absolute limit on the volume of service that can be provided by each institution during the prospective budget period. This service volume limitation should ultimately be expressed as a dollar budget ceiling, subject to carefully controlled retrospective adjustment for specific occurrences. However, the dollar budget ceiling should be established based on targets for physical measures of hospital service utilization, such as the number of discharges for which reimbursement will be provided during the coming budget period.

Without limitations on the volume of services that can be provided—as opposed to specification of payment rates for units of service—the structure of the American health care system ensures that hospital care costs will continue to rise. This is so because technology, facilities and program expansion, and service utilization are the driving forces behind hospital cost increases. Each of these grows on a commitment to unlimited service volume. Physicians—who determine the type and volume of care that will be provided—simply cannot be expected consistently to guard the purse of the Government or other third-party payers when their training and rewards are based on maximizing service. With humanely established service volume limitations, however, physicians can be depended upon to set sound priorities for patient treatment.

With a prospective budgeting process in place that includes establishment of firm budget ceilings, a sound system of utilization controls can help physicians and hospital managers live within their budgets. Thus, utilization controls play a complementary role in an overall cost containment program. Such controls likely can never be sufficiently strong and consistently applied to eliminate the need for service volume limitations.

Additionally, the service volume limitation for a hospital provides the critical link between prospective reimbursement and the regional health planning process. The budget ceiling for a hospital should be developed based on the target volume of activity for the specific service to be provided by the hospital as established in a regional health plan. Following this approach, the reimbursement agency can serve to help ensure implementation of the regional plan.

About a year ago, my associates and I surveyed 20 or so prospective reimbursement programs in operation in this country. None included provision for establishing service volume limitations; and none had been markedly successful in containing the rate of growth in hospital care expenditures. Service volume limitations are, however, an integral part of the national health service in the United Kingdom. As we all observe, the NHS has serious problems. However, these problems are demonstrably due to a simple lack of adequate resources to fund essential care, and to the ways the service volume limitations are set. The fact of the matter is that by most measures the population of the United Kingdom is as well cared for as, and is healthier than, our own. Moreover, UK per capita expenditures are about 30 percent of our own, and have been growing at a significant slower rate.

Setting service volume limitations means rationing health care. However, in this country, it does not have to mean failure to provide essential care to those who need it. Rather, it means developing over time a changed way of thinking about who needs what care. This changed way of thinking will only follow a change in the structure of the health care system that introduces the realization that resources for the provision of care are, indeed, limited. Prospective reimbursement, based on the concept of service volume limitations, provides the way of bringing about this new way of thinking. The demographic and epidemiological data and techniques are available to provide the basis for developing such an approach. With sensitive implementation, this fundamental change can be made without jeopardizing the quality of American health care.

PROSPECTIVE REIMBURSEMENT SYSTEM ELEMENTS

The principal purpose of my testimony today is to emphasize to the Subcommittee the critical need for the inclusion of service volume limitations in any prospective reimbursement system aimed at controlling the rate of increase in expenditures for hospital services. Within the context of this overall approach to prospective reimbursement, I believe that an effective system should operate at the state level and should include the following primary elements:

1. Administration by an independent commission composed of representatives of providers, payers, and consumers. This commission should have sufficient staff to manage the reimbursement system.
2. System concentration on supporting control of overall hospital expenditures and, in concert with regional planning authorities, distribution of services among hospitals.
3. Development of a "lump sum" budget for each hospital, based on: (a) hospital peer groups standard cost allowances per square foot and per patient day for space and occupancy costs, respectively; (b) peer group standard costs per discharge for most in-patient treatment, and per visit for outpatient services; (c) forecast costs or expenditures for teaching activities, facilities development (as approved by regional planning authorities), and sunk or committed costs (e.g., depreciation, property taxes); and (d) total budget ceilings based on (1) demographic and epidemiological evaluation of each hospital's service area, and (2) policy decisions.
4. Substantial freedom for each hospital manager to deploy his or her institution's lump sum budget in the manner he or she feels will best implement the hospital's role in the regional health plan and meet the population's care needs.
5. Provision for retention of budget "underruns" by hospitals to carry out new care programs in line with regional health plans. Full absorption of budget overruns by the hospital.
6. Retrospective upward adjustment of budgets only to reflect occurrences outside the hospital manager's control. The occurrences for which retrospective adjustment will be made should be clearly set out as a part of the total system specification.

COMMENTS ON PROPOSED LEGISLATION

The legislation currently proposed to improve the effectiveness of Medicare reimbursement systems in helping to contain hospital cost growth includes a number of these important prospective reimbursement system elements. For example, the concepts of discriminating among the hospital cost elements that will be subjective to prospective reimbursement and establishing per groups of hospitals for these cost elements are sound and necessary system elements.

However, I believe there are two fundamental shortcomings in the proposed legislation. First, the prospective reimbursement system described in the legislation does not include a provision for establishing service volume limitations. Secondly, the proposed legislation does not include steps for moving from implementation of prospective reimbursement for Federal beneficiaries to implementation of such a system for all hospital care.

Mr. ROSTENKOWSKI. Thank you very much. There are no questions. The committee will stand in recess for 5 minutes.

[Whereupon, a brief recess was taken.]

Mr. ROSTENKOWSKI. The committee will resume.

Mr. Robert Marvin?

STATEMENT OF ROBERT B. MARVIN, ADMINISTRATOR, HAMILTON COUNTY, FLA., MEMORIAL HOSPITAL

Mr. MARVIN. I am Robert Marvin, administrator for Hamilton County Memorial Hospital. I know time is of the essence. I would rather make judicious use of 60 seconds to make a couple of remarks than read my statement.

Mr. ROSTENKOWSKI. Your entire statement will be included in the record.

Mr. MARVIN. Let me say I am a hospital administrator and have worked in several areas of hospital administration, large hospitals and small hospitals. I have not seen any group who represents the small rural hospital and there are many of those in this country.

I am deeply concerned about the small rural hospital. My presentation discusses the impact of Federal and State legislation and the effect of implementation of that legislation on costs as they affect our hospitals.

I feel that a large amount of the cost increases have come from legislation itself, not only from medicare and Federal legislation, but the way they have been interpreted by State agencies and the things that small hospitals have had to do to comply with State regulations and Federal regulations. I have great concern about that.

I am also concerned about the ability of small hospitals to meet the changes that are developing. I just beg you that when you develop recommendations for medicare reimbursements in the future, that you consider the ability of small rural hospitals—and there are large numbers of them—to comply with this type of regulation.

We have a lot of problems. We don't have the expertise and we don't have the financial facility to meet a lot of the requirements. In our hospital we are providing daily room and board for patients at $48 a day. Very few hospitals in this country are able to do that and that is typical in our area.

Frequently we are almost on the verge of financial starvation because medicare threatens our very lifeblood in the form of reimbursement that we get.

Let me stop here and answer any questions you might have.

[The prepared statement follows:]

STATEMENT OF ROBERT B. MARVIN, ADMINISTRATOR OF HAMILTON COUNTY MEMORIAL HOSPITAL, JASPER, FLA.

Thank you for the opportunity of preventing one rural hospital's opinion on the reasons for the sharp increase in hospital costs which this Sub-Committee has stated in its Press Release is "The major factor driving up Medicare Expenditures." The Sub-Committee also stated that much of this problem relates to Medicare Reimbursement and, in particular, to the adoption by Medicare of retroactive cost-based reimbursement.

Frankly, I do not see the problem from that point of view at all. The method of Medicare Reimbursement, as it applies to the hospital I represent, is already so damaging to the hospital that any changes that would in effect lower our reimbursement might easily spell the end for hospital care in our county altogether. I am, of course, concerned about the rising cost of hospital care, but I believe these costs come not from the method of retroactive reimbursement, but from the system itself. I ask you to consider some of the factors that have caused hospital costs to go up so sharply.

1. Hospitals operate 168 hours a week, not 40 hours like most businesses, so changes that affect hospital employees are felt more crucially by hospitals than similar changes in other industries.

2. Wage and hour requirements have caused sharp increases in hospital costs as the result of minimum wage changes. Social Security and Retirement costs have also added their toll. In our hospital and all hospitals in Florida that participate in the state retirement program, an additional five percent was added to our salary budget as the result of state legislation in that area.

3. Federal requirements for staffing as interpreted by State Agencies, such as, Florida's huge Health and Rehabilitative Services, have placed many expensive, highly trained personnel, such as Registered Nurses, in unproductive administrative categories.

4. Tremendous amounts of man-power have been allocated to administrative functions as the result of licensing and certification requirements interpreted by licensing agencies, and, frankly, the talent is largely wasted and spreads bureaucracy at the local level where costs go up and up. Hospitals are surveyed to death, and the surveys cost plenty.

5. Minimum standards are just too high to provide hospital care at reasonable cost. Many life safety code interpretations are foolish and unnecessary and result in unproductive cost increases, not only at the hospital level, but by the ridiculously large agencies that make the interpretations. Interpretations have also required that hospitals provide offices for dietary supervisors, housekeeping supervisors, maintenance personnel, laboratory chiefs, as well as the traditional office for the Director of Nurses. Much of this is really unnecessary and adds an unreasonable amount of cost. Everything must have a manual and there must be regular meetings for everything from Fire Drills to Disaster Drills, General Staff Meetings and Professional Staff Meetings, regular inspections of everything, including the ground plug on every electrical wire in the hospital. One inspector even suggested replacing all ground plugs with clear plastic see through types so that the ground wire can be more easily inspected. Even the tension in wall plugs must be regularly inspected and the findings properly recorded. There must be meetings of the Infection Committee, Utilization Committee, Safety Committee, Inservice Training Committee, etc. There is hardly time left to take care of patients and in a small rural hospital, the number of committees and meetings seems all the more ridiculous. Even Blue Cross is in the act with Cost Containment Committees and so many regular visits from Blue Cross representatives that they seem almost a part of the regular staff. Malpractice insurance carriers add their own requirements and recommendations and costs go up and up.

Is it really necessary to replace every hollow door in a totally fire resistant brick building with much more expensive solid core doors, plus make hundreds of such changes throughout a hospital to make it conform with new codes? Did anyone ever evaluate the cost of updating all the hospitals in this country to make them conform with new codes? The codes still promise more changes and more costs for the future and I wonder if anyone has evaluated those costs? Can we afford these new codes, and are they really necessary?

6. The multitude of agencies, inspectors, administrative personnel, agency heads, supervisors, and professionals all are expanding their bureaucratic worlds and passing the cost of that expansion on as an increase in hospital costs. Utopian standards which are the product of this bureaucracy are being applied to hospitals even while this Sub-Committee reflects on the form of Medicare Reimbursement. In all this bureaucratic mess very little gets done and the size of the agencies of which I speak is in itself destructive. Consider that last year Florida's own Health and Rehabilitative Services required our hospital to update our

facility with many expensive changes to meet the Life Safety Codes which I have already mentioned. We have obtained the money for these changes from the sale of Revenue Bonds, a lengthy and difficult process I might add, we have obtained a Certificate of Need, which required many meetings plus the preparation of a difficult document of more than 50 pages, and we have an architect and have signed a contract with a construction company but the state agency has not yet released the plans that they have been reviewing since January 20th. Our costs will go up as a result and so will Medicare's reimbursement. There is just nothing that our hospital or any hospital can do in the face of all this red tape and it adds an additional burden to hospitals and to Medicare.

7. The government reimburses hospitals at cost, or lower than cost, if charges are lower than cost, so frankly, what better or more advantageous form of reimbursement can the government find than that. If you want to control costs, help us by stopping the unnecessary increase in requirements that drive costs up.

8. Competition by the Federal Government also drives costs up. Salary levels at the Federal Level are unrealistic in many areas, especially in the rural areas, and force us to pay higher salaries than we otherwise would have to just because the Federal Government pays them. For example: Registered Nurse Salaries at VA hospitals in our area are $4,000 a year higher per nurse than they need to be. Such a salary level increases the cost of government hospitals and increases our reimburseable cost as well.

9. The overproduction of hospital beds, which all the fancy Health Councils have done little to correct or stop, also causes hospital costs to go up. Some effort must be made to stop the competition between hospitals for patients.

10. Malpractice costs in our hospital have gone up in just two years from $1800 a year to over $23,000 a year. Something must be done in this area.

In closing, therefore, I believe the major factor in rising hospital cost is not the present form of reimbursement, but rather it rests with the over-expansion of the industry and, in particular, with the administrative agencies that supervise the health industry and interpret the rules and regulations as they see fit. Minimum requirements are just too expansive, and there is just too much bureaucracy at the provider level. The health industry is overburdened with agencies, inspectors, and a mountain of paperwork. Thank you.

Mr. Rostenkowski. How large a hospital do you have?

Mr. Marvin. Thirty-one beds and we are growing to 42 beds.

Mr. Rostenkowski. How large is Jasper?

Mr. Marvin. Hamilton County is 8,000 population, 3,000 people in the city of Jasper.

Mr. Rostenkowski. Do you think the Federal Government could be more efficient if you had a direct relationship with it other than going through the State?

Mr. Marvin. Yes, sir. The State agencies are horrendous monsters that slow down the effect of implementing most of the Federal regulations. For example, we want to grow to a 42-bed hospital. We asked Florida's HRS to give us permission to grow.

They said we must. They told us we had to comply with Federal guidelines. We wanted to do it. We went out and floated a $550,000 revenue bond issue. We got a certificate of need. We got the support of the community behind us.

Yet Florida's HRS has been sitting on a review of the architect's plans since January 20, almost a 7-month delay.

Mr. Rostenkowski. Do you treat many medicaid patients?

Mr. Marvin. Yes, sir, for $82.64 a day, all-inclusive.

Mr. Rostenkowski. Do you have a great time lag in reimbursement?

Mr. Marvin. No. That comes along quite quickly. What does bother us is the implementation of regulations from the State agencies and the fact that we don't recover our costs. We have to have committees that are unnecessary in a small rural hospital: a safety committee, a disaster committee, and so forth.

We have to check electrical wall plugs. Every plug in the hospital that goes into a wall socket has to be checked. We have to check it to make sure the tension on plugs in the wall sockets is sufficient to meet State requirements.

Mr. Rostenkowski. How would different Federal regulations help you avoid that problem?

Mr. Marvin. The Federal regulations are so broad they give State agencies great interpretive ability. These middle-level inspectors come in and they make unbelievable demands on hospitals. Where is your safety committee? How often are you checking your plugs, and so forth?

Frankly, they drive us crazy. We use highly-prized, registered nurses for ridiculous jobs in our hospital, yet we can't get registered nurses. Competition from the VA hospital 30 miles away from us is unbelievable. The VA hospital pays them $4,000 a year more than any other hospital in our area does.

We have a lot of competition from the Federal Government, from the State agencies and Blue Cross is the same way. I know Blue Cross made an effective presentation here, but Blue Cross has enough time and money to send people floating around these hospitals on such a frequency that they seem like they are one of our own staff members. Doesn't this increase costs to patients?

We could keep our costs down if you wouldn't make the operation of a hospital so supersophisticated. Small rural hospitals, want to give the best care to their patients, but we have to have sophisticated—especially sophistication at administrative level organizations which are not really needed to provide that care.

We have good equipment in our hospital. We have good ambulances, beautiful radios and a fine staff. Some of the sophisticated committees that we have to have, and the use of these committees, are really superfluous and this is a problem for all the hospitals in our area.

Mr. Rostenkowski. Thank you, Mr. Marvin.

Professor Worthington?

STATEMENT OF PROF. PAUL WORTHINGTON, DEPARTMENT OF ECONOMICS, SLIPPERY ROCK STATE COLLEGE, PA.

Professor Worthington. I am Paul Worthington, associate professor at Slippery Rock State College, Slippery Rock, Pa. I speak here on behalf of myself.

The approach most widely used to reimburse U.S. hospitals in private insurance plans or under medicare and medicaid programs is cost-based reimbursement. A price system such as this, based on hospital expenses per patient day, per case, or some other unit of activity, does not tend to satisfy any general conditions for the efficient use of resources. To the contrary, it creates a system of perverse incentives and subsidizes an array of hospital practices that are widely believed to be wasteful. These include such phenomena as the duplication of facilities and equipment, idle capacity, and a bewildering diversity, even among neighboring hospitals, of the expense and service content of virtually similar medical cases. Perhaps most frustrating are the increases in costs from year to year, which continue to surprise and impede those who are charged with managing reimbursement programs, and which threaten prospects for achieving stable and dependable programs.

In 1974, my colleague, Dr. Jesse Hixson, and I commenced research into the question of finding an alternative to cost-based reimbursement in response to the 1972 amendments to the Social Security Act. Section 223 of P.L. 92–603 was of particular interest to us since it appeared to signify the recognition of a new idea, that perhaps the expense of a particular hospital should not necessarily govern the rate determined for it.

The results of our inquiry, after a few months of study, are incorporated in the paper "An Administered Price System for Hospitals" which we have given to this committee.

[The material referred to has been retained in the subcommittee files.]

Professor WORTHINGTON. Our research, which continues, has moved beyond considerations for the initial empirical design and implementation of the system we propose—considerations with which about half our paper is concerned. However, the basic properties that centrally determined and administered prices (or reimburesment rates) must possess in order to induce hospitals to voluntarily seek out patterns of resource use which will satisfy general conditions for efficiency are set forth in the paper.

These properties follow from a consideration of the conditions which must tend to be satisfied in order for production to be efficient. The consideration for conditions to be satisfied also makes clear why no cost-based reimbursement system can hope to succeed.

I should like, in the following paragraphs, to enumerate and comment briefly on the 3 fundamental properties of administered prices which appear to be essential.

First, the prices which are set by the reimbursement authority must be beyond the control of individual hospitals. That is, the prices must be regarded as upper bounds or parameters of the economic environment by hospital decisionmakers.

COMMENT

Under parametric prices, revenues are obtained only by the provision of services. Hence any action contemplated in the hospital which gives rise to expenses must be evaluated in terms of the productivity implications of that action.

This situation is in sharp contrast to cost-based reimbursement, where the hospital is allowed to influence the terms (rates) by which it obtains revenues.

Under cost-based systems there is no need to be constrained by productivity implications, since new revenues can be obtained by using the expense of activities to increase the reimbursement rate.

To the extent a hospital is able to discover and implement the opportunities for providing services and using resources that are made available by the parametric prices, it will tend to satisfy an important efficiency condition—although such may be no part of its intentions. In particular it will tend to choose patterns of services and resource use that will cause marginal or incremental costs to approach the administered price limits.

Second, (*a*) The unit of output to be priced must be defined as the broadest possible aggregate of service components which can be identified generally as a unit for satisfying demands under the program. The case or hospital episode is appropriate for this purpose.

COMMENT

If prices are set for individual components of service—for exemple, room service, tests and procedures, use of operating rooms, or patient day—the hospital will be compelled, in considering new expense decisions, to consider productivity solely in terms of those components that are priced—since it is only by altering their production rates that revenues can be increased. Nothing in such prices constrains the amount of services that a hospital might choose to use in producing a particular type of case. Nor is there any incentive to choose a least costly combination of service components for cases in situations where it is possible to choose from among alternative combinations. Choosing least costly combinations, for example, may require incurring relative marginal costs for services that do not correspond to the relative prices which have been set. Thus there is a conflict between the productivity considerations required in order to judge revenue opportunities, and the productivity considerations required in order to minimize the cost of producing the case.

(*b*) A second essential aspect of this property is that cases tending to differ with respect to the behavior of incremental or marginal costs must be treated as different types of output; and, accordingly, must be assigned price limits which take differences in marginal cost behavior into account.

COMMENT

Different price limits are necessary in order to enforce a strict relationship between revenue and output which will not obscure the implicit productivity test that is required in order to reach cost decisions. If cases are assigned the same price, a cost decision need not be based on a fully compensating productivity test since a surplus can be generated by expanding the production of those cases which tend persistently to have incremental costs less than the average of incremental costs. Moreover, as hospitals can be expected to take actions in this regard from their own individual perspectives, there is no expectation possible that resources will be used in equally productive ways among hospitals. Hence, it will not be possible to satisfy the latter condition as general conditions for efficiency require.

Third, the prices imposed by the administered price system for each type of case must be the same for all hospitals facing essentially similar economic environmental conditions.

COMMENT

The exogenous economic conditions of the hospital's environment determine the ultimate bounds on its behavior by limiting the choices available for using resources in alternative ways, for providing alternative types and volumes of services, and for achieving particular cost results. Hence, all hospitals facing similar sets of resource market and demand market conditions have the same potential capability of achieving the same degree of efficiency. By imposing the same prices for cases on all hospitals in a given economic environmental context the administered price system will require the hospitals to apply the same criteria in judging and adjusting the productivity of resources.

Again, to the extent hospitals are able to discover and implement the opportunities that are made available by the parametric prices, marginal costs for each type of case will tend to converge on its administered price and, by implication, equalize the productivity of given resources in particular uses across the group of hospitals. The tendency for satisfaction of this condition is of monumental importance, since it is the only condition which, if satisfied, eliminates duplicated, redundant, or otherwise wasteful allocations of resources within and among hospitals.

To conclude, prices which possess these three properties do have the capacity to enforce a particular behavior of actions by hospitals, actions which when implemented result in the satisfaction of general conditions for efficiency. Hence, these properties appear to be the guiding principles which must be observed in choosing operational rules and procedures for managing the administered price system. We realize that knowledge of neither the appropriate environmental clustering of hospitals, appropriate classifications for cases, nor optimal resource uses or marginal cost conditions can ever be known unambiguously, or with scientific precision.

Such optimal associations and cost conditions are in any case undergoing continuous change, a circumstance which severely limits the usefulness of knowledge of a specific current or historical state of conditions, even if it could be known. Hence, while operating rules and procedures can be designed to product prices which observe the principles we propose, the main functions with which they will be concerned, so far as continued application through time is concerned, will be with the discovery, interpretation, and reaction to changes in the data which define the problems of resource allocation. That is, the management of administered prices must have the character of a trial-and-error process, always striving to impose prices which will satisfy what are believed to be particular conditions for efficiency, but ever sensitive to new data and capable of prompt reaction to such information. We have few doubts that a program of procedures and rules for administering prices with these capabilities can be designed and implemented. But we are equally convinced that this will be possible only if the fundamental properties of the prices to be administered are clearly understood and observed in practice to all possible extent.

I thank you.

[The following was subsequently received for the record:]

COMMENTS ON HEARINGS BEFORE THE SUBCOMMITTEE ON OVERSIGHT: MAY 14, 1976

(By Paul N. Worthington, Associate Professor, Slippery Rock State College)

1. *As regards the effectiveness of prospective reimbursement, no significant claims are made for cost saving.*

COMMENT: There are three possibilities which can account for this testimony. (a) The prospective reimbursement schemes described and/or researched are not effective. (b) No one knows what to look for as an effect, or how to look for it. (c) No one has looked (rigorously, that is).

2. *Administrative and legal problems associated with present schemes are bewildering, costly, and profuse.*

COMMENT: Despite general agreement on this point, and the fact that the schemes appear to have no significant effect, the witnesses suggest that if prospective reimbursement is to work it must not only regulate the prices hospitals receive but also total costs, revenues, utilization, case-mix, capital investment, number of beds, etc. That is, more bewildering, costly, and profuse administrative and legal issues must be built into the systems.

3. *Neither the expert witnesses nor the representatives from S.S.A. offer explanation as to why prospective reimbursement according to the schemes described or researched can be expected to save anything. Nor do they offer any explanation as to why the improvements they advise will make the schemes work—when at present they evidently do not work.*

COMMENT: The fact is none of the witnesses is able to say what "work" means. There are vague references to saving money or constraining the increase in hospital expenditures; but, aside from a casual reference to statistically significant (or not significant) coefficients in a regression equation, no one even talks about a success criterion. If the witnesses do not know what is expected to happen as a consequence of imposing prospective reimbursement, then it is not, of course, surprising that they are frustrated in attempts to find out what (if anything) the effects are.

4. *The payment systems described and research are based entirely on accounting methodologies; and their preoccupation is focused in virtually all respects on the hospital management problem of administering cash-flow.*

COMMENT: Despite Dr. Cohen's complaint that accountants have had too much to say about pricing in hospitals, neither he nor any other witness seems ready to propose that the accounting methodologies characterizing present schemes, and the so-called improvements recommended as well, be dropped. (It is not the accountant who is at fault here; it's the *method* that wreaks havoc). The pretense is maintained, like the devotion of high romance, that by studying the accounting reports or the proposed budgets one can determine whether or not too much money is being spent!

In essence the reimbursement schemes discussed are nothing more than cash-flow strategies—designed to spare the hospital financial embarassment. This includes the "formulas" used by New York State and the State's Blue Cross plans, which are referred to erroneously as "statistical formulas." This is not new, since historically the reimbursement of hospitals has always been viewed as a problem of seeing to it that the hospitals are paid enough to cover their expenses. The prospective twist simply involves planning out the administration of cash-flow a year or so in advance. What none of the witnesses appear willing or able to tell Congress, however, is that the cash-flow problem arises as a consequence of the allocative decisions that are made *before* anything takes place. And it is in the choice of allocative alternatives (ways of using capital and labor to achieve alternative outcomes in providing services) that a hospital either achieves or fails to achieve efficiency. If any payment system is to have an impact towards achieving efficiency in hospitals it *must* have a binding, constraining impact on the allocative choices that are available to the hospital *before* the administrative problem of dealing with cash-flow arises. That is the reimbursement system must not be a device for underwriting a particular cash-flow plan which conveniently subsidizes use of resources and provision of care as they are already organized. To the contrary, by constraining alternatives for cash-flow it must compel the hospital to change what it is doing, to choose from among allocative alternatives *only* those alternatives that can be financed. The trick, of course, is to limit these alternatives in such a way that the hospital will be led *by its own interests* to find and choose from among allocative choices those which when implemented tend to result in efficient operations.

The witnesses are not, obviously, unmindful of this problem—hence they propose to saddle their prospectively determined cash-flow strategies with utilization control reviews, audits, "productivity screens," planning approvals for beds, facilities, appeals, law suits, etc. That is they propose to force the hospital into making the "correct" or efficient allocative choices—under the pretense that they know (or can know) what the efficient choices are; then through the reimbursement scheme, provide a cash-flow that will pay for what they've done. It is precisely because they *don't* know what the efficient allocative choices are, however, that their schemes contain no logical prospects whatever for achieving efficiency. This is not a suggestion that the hospital (or anyone else for that matter) possesses such critical information. The efficient use of resources is unknown and must be discovered; such uses, moreover, are subject to more or less continuous change. It would seem obvious, accordingly, that the best place to search, with reasonable prospects of learning about such matters, is inside the hospital itself. But this will require initiative and continuing diligence within the hospital, a willingness to work that is *not inspired by force.*

I agree totally with Dr. Cohen, that accountants, in the past, have had too much to say about paying hospitals. They still have too much to say about it.

5. *Much of the research on Section 222 projects, as reported by S.S.A. (Dr. Gaus) is irreparably flawed by an incompetent methodology, and should not be regarded as a serious effort.*

COMMENT: The research effort in a number of these projects is largely wasted due to an amateurish mistake in methodology. I am able to speak directly to this point, since, by coincidence, I am personally familiar with the technical designs of the projects, and I was in attendance at several meetings during 1974–75 among SSA staff and contractors, and among SSA staff members, where these technical matters were discussed. Although the scientific merits of the methods utilized are seriously undermined by a number of procedures the most serious flaw is the use of the control group, dummy variable (0.1) technique for attempting to find a significant impact on hospital costs which can be attributed to prospective reimbursement. Cost for hospitals in one state where prospective reimbursement is applied, are compared with costs for hospitals in another state where prospective reimbursement is not applied. The object (statistically) is to reduce or account for as much of the variance in hospital costs (considering all hospitals) as is possible by the associations between costs and all other things which would be expected to affect costs on the basis of economic theory: and *then* to see if the variance is reduced further (by a statistically significant amount) by distinguishing between the experimental group of hospitals and the control group. This is attempted by adding a new (dummy) variable to the equation being estimated, with a value of 1 for each of the experimental hospitals and a value of 0 for each of the control hospitals. The significance of prospective reimbursement is supposed to be revealed by assessing the significance of the coefficient estimated for the dummy variable. But the problem is obvious: *anything might* cause hospital costs in one state to vary from one state (city, place, etc.) to another—such as fire laws, professional standards, customary working condition, insurance laws, temperature. The list can never be exhausted because we can never know for sure that something (anything) doesn't belong on it. No matter how valiantly one attempts to match up an experimental hospital with its control twin (which itself proves to be impossible once more than one variable is selected as matching criteria), the dummy variable procedure cannot make any distinction between the items that may be on the list.

Suppose, to illustrate, we call one thing on the list of possible effects "prospective reimbursement," and everything else the "Wabash River" (as might apply in the Indiana project). The outcome of the control group analysis has two possibilities—the dummy coefficient is either significant or it is not. If it is, we might wish to say it's because of prospective reimbursement; but it might be because of the Wabash River. On the other hand, the coefficient may not be statistically significant, in which case we may be tempted to say that prospective reimbursement has no effect. But it may be that it *is* effective. It's just that its effect is being offset and obscured by the effect of the Wabash.

The point to this rather labored and superficial example is that the control group-dummy variable methodology is powerless in this situation to say anything one way or the other about prospective reimbursement. For similar reasons, the "before and after" test on cost functions, utilizing the same principle, is impotent.

The contractors on these projects are not at fault, as I understand it, because the R.F.P. to which they responded required an application of the control group methodology.

I might also add that in discussions of this flaw in the technical research approach, those who were in charge seemed to think the point was trivial and could be ignored. I did not get the impression that the power of Congressmen to understand statistics was held in much regard. I, of course, believe the mistake is fatal.

P.S. I notice that Dr. Gaus tends to refer the results (in some cases) as showing a minor costsaving effect even though coefficients could not be shown to be significantly different from zero. The *correct* interpretation of this result (if any interpretation were possible) is that the test fails to show that prospective reimbursement has any effect at all.

6. General: The delays to which the Oversight Sub-committee addressed itself are not, in all likelihood, the usualy bureaucratic foot-dragging—fighting over who will get to spent they money. The reason is probably buried in Mr. Smith's defense of these delays. He claims the problem is very complex (which it is) and that it will simply take more time to find out how to pay hospitals. My interpretation of this admission, and in view of the progress of the research effort mounted thus far (including that of B.H.I. in attempting to classify hospitals pursuant to Section 223, P.L. 92–603) is that nobody knows what to do, or where to start—with all due respect for Mr. Smith's high opinion of the reputation SSA enjoys in the research field.

Mr. ROSTENKOWSKI. Thank you, Professor Worthington.

That concludes the testimony that the committee will receive.

The committee stands adjourned.

[Whereupon. at 5:03 p.m., the subcommittee adjourned, subject to the call of the Chair.]

[The following was submitted for the record:]

STATEMENT OF THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The major cause of the Medicare program's cost problems is the outmoded and unsatisfactory organization and distribution of health services that characterize the nation's health care system. A unique opportunity was lost when the Medicare program was enacted because of a perhaps well intentioned but clearly misguided intent of avoiding conflict with the established order of health services. Thus, the primary purpose of the Medicare program has been to help pay the cost, not change the pattern of health care. This program, with few exceptions, excepts all the inefficiencies of the existing structure of health care. In the long run, the only fully satisfactory solution is a comprehensive, compulsory health insurance program for all age groups that will reform the existing delivery system.

The cost problems of the Medicare program arise out of the whole pattern in which health services in this country are provided and paid for. While it is true that part of the increases in health costs are the result of a general inflation and of especially strong inflationary forces in the health field, what is more important is that efficiency and economy are virtually nonexistent. The health care industry is insulated from the rigors of price competition.

Medicare was enacted to deal with the financial problems of the aged in obtaining medical care. It is fair to say that Medicare has been quite successful in attaining this goal.

Unfortunately, Medicare has very little authority to determine what care should be provided or in what way it should be provided even where current arrangements for care may be clearly inefficient or unduly expensive. Dealing with these matters is left to those who provide medical services. The main authority of Medicare is to decide what will be paid for services rendered. In short, the program had done nothing to overcome the problems inherent in the defects in the overall health care system.

Hospital care is paid for by Medicare and private insurance on a cost basis, so that the hospital is assured of getting full payment no matter how much of the cost is due to waste and poor management or to expansion of facilities and services beyond what is required to meet the community's needs. Hugh volumes of hospital services are ordered by physicians who have no financial stake in keeping down hospital costs. Physicians themselves are paid on a piece-work basis that rewards volume rather than quality of service and that provides no financial incentive to keep the patient well and out of a hospital.

The cost reimbursement prescribed in the Medicare law subsidizes inefficiency. And every additional service, so long as it cannot be disallowed or be shown to be clearly unnecessary, results in another charge and another Medicare payment.

Recognizing that these problems are not amenable to easy solution, the AFL–CIO nevertheless believes that renewed efforts should be made to stimulate patterns of care in the Medicare program in which there is incentive for efficiency. An important principle is that coverage should be comprehensive to avoid twisting patterns of care in the direction of expensive institutional services.

Comprehensive group practice prepayment plans provide a model. Under such plans, medical groups contract to deliver health services to plan members within the framework of a budget as determined by the contract. Under such an approach, there is a financial incentive to keep the patient well and to avoid unnecessary hospital care. Hospital utilization under the prepaid or contract arrangement is about one-half of what occurs under the fee-for-service system. We believe the Medicare law should be changed to encourage to a greater degree payment for care in this kind of comprehensive fashion.

Another possibility for improvement under Medicare is to base the hospital payment on prior budget approval or on the basis of average payments to all hospitals rendering similar services under comparable circumstances. There have been some attempts to deal with these issues but, unfortunately, none of them have been satisfactory.

Existing law gives the Secretary of HEW authority to establish limits on hospital costs to be recognized as reasonable based on comparison of the cost of covered services by various classes of providers in the same geographical area. The provisions are to be applied prospectively so that hospitals know in advance maximum costs allowable and have an opportunity and incentive to achieve economies to avoid non-reimbursable costs. Cost reimbursement is not compatible with efficiency objectives. A reimbursement formula should recognize only those costs incurred by a prudent and cost-conscious management.

We strongly supported the requirement of existing law that HEW develop experiments and demonstration projects designed to test various methods of making payments to providers of services on a prospetcive basis. Unfortunately, little has been accomplished. What is needed is a speedy and sustained effort in this area in order to lay the groundwork for a major program of prospective reimbursement. The present "reasonable cost" reimbursement formula neither rewards efficiency nor discourages waste and ignores the opportunity to use money as an inducement to superior performance. Specified payment in advance would put a premium on efficiency and would stimulate more economical use of resources and manpower.

The AFL–CIO supports such approaches for controlling hospital costs as long as the cost savings do not come at the expense of the patient. For it is providers and not patients who determine the utilization of health services. For example, the doctors determine the hospital used, the services required, and the nature of the patient's treatment. The patient is essentially an innocent victim and should not be required to bear the cost burden of the improper actions of others. Control of health costs should be approached from the providers side since the aim should be to control excess costs at the expense of those who are responsible for them. It is unconscionable to place the burden on innocent, low-income people thereby magnifying their already difficult problems of securing adequate health care.

To work effectively, such budget controls must include the hospital's total budget not just that portion applicable to Medicare. We oppose limits on Medicare payments along the lines of those proposed by the Administration. Such an approach leaves the hospital free to pass on increased costs to their non-Medicare patients. This shift costs but does not control them. The result is increased premiums for other health plans including collectively bargained plans. In short, such proposals are unsatisfactory because the incentives for bringing excessive costs under control are minimal since hospitals will have available the easier alternative of passing them to non-Medicare patients.

The law, regulations and administration all must be altered to better protect patients. The regulations should require that providers bring their costs within reimbursable limits during a specified time period. If they do not do so, the program should deny them participation until they do. This would insure that providers would make a vigorous effort to bring costs within proper limits.

We believe it essential to broaden home health services in order to provide a major alternative to costly institutional care. Unfortunately, there is still confusion as to what Congress intended in regard to home health care benefits under the Medicare program. The program has been administered much too narrowly consisting primarily of home nursing services rather than aiming at the goals of coordinated multidisciplinary services provided to patients in their homes.

The program has created a barrier between the health needs and the social needs of homebound patients. Services to keep the home clean, to prepare meals and to transport patients to health services are often as important in preventing institutionalization of patients as direct health services themselves. Indeed they may be vital to health and, in some cases, to life itself. The Medicare program should include services of these kinds to increase the possibility of appropriate choice, to reduce expensive institutionalization, and to meet essential health needs of many beneficiaries.

The number of reimbursable home visits should be increased beyond the 100 now set as the maximum in each of the two programs, Part A and Part B. The program also should provide a life-time reserve similar to the life-time reserve for hospitalization in Part A of Medicare. In addition, the requirement that a patient must be hospitalized for 3 days to be eligible for home health services under Part A should be eliminated. Too many patients are unnecessarily institutionalized for the purpose of establishing eligibility for home health services or placed in costly hospitals or extended care facilities because appropriate home health services are not available.

Since home health services of the Medicare program are task-oriented rather than need-oriented, services are too often delivered in a fragmented fashion. The program should encourage non-profit HMO-type organizations that would provide (directly or by contract) and coordinate the wide variety of required services including institutional care. Financing should be based on prepaid, per capita payments utilizing prospective budgeting. We believe home health services and institutional services should be coordinated within one capitation payment. This represents the best approach for insuring that the patient receives the appropriate services combined with effective cost controls.

The reforms we have recommended would help resolve many of the cost problems of the Medicare program but we feel others are essential as well and among them urge the following additional reforms:

1. A low occupancy provision should be included in the Medicare law which would restrict reimbursement to low occupancy hospitals. A hospital with a low average occupancy rate would not have payment made by Medicare for costs which are unreasonable in terms of occupied bed costs.

2. Hospitals should be required to employ a full-time medical director and various department heads and all hospital-based physicians should be paid by the hospital in order to give hospital administrators greater control of the hospital's budget.

3. All hospitals, as a condition of participating in the program, should be required to establish a formulary of prescription drugs and to purchase drugs for this formulary by generic name on a competitive basis.

In the long run, only the adoption of a national health insurance program, such as the Health Security Program (HR21), will guarantee a health care system capable of providing comprehensive quality care and of containing cost increases. But the need for a comprehensive national health program should not detract from the need of making these essential changes in the Medicare program as soon as possible.

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., August 3, 1976.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, Longworth House Office Building, Washington, D.C.

DEAR CHAIRMAN ROSTENKOWSKI: We have noted that your Subcommittee is holding a 1-day hearing concerning recommendations for revisions in the Medicare reimbursement system for hospitals.

Within the notice issued announcing those hearings, there are listed several suggested issues on which the Subcommittee invites comment.

We are particularly concerned over some of those Subcommittee issues and would like to submit the following comments.

The Subcommittee's investigation of possible revisions of reimbursement mechanisms under Medicare for hospitals apparently centers on its concern over what it perceives to be unacceptably increasing costs in health care.

We would point out to the Subcommittee that the increase in costs is attributable more to "natural" causes than to any other factor. For example, improvements in the quality of care, increased accessibility, expanding demand, improved technology, expanding government programs, demographic changes, economic inflation and the increasing cost for doing business (including skyrocketing liability insurance premiums) have all added their toll to a more stable and predictable total federal expenditure for its health care programs. These causes cannot in the long-run be corrected by curtailing the reimbursement mechanism for hospitals or for physicians. It must be borne in mind that any artificially imposed and arbitrarily limited ceiling on the part of government for program benefits which have been promised the populace can only result in a lowering of quality, a cutting off of benefits, or a shifting of the financial responsibility for payment of public programs to private patients.

In one of the specific approaches being considered by the Subcommittee to controls on hospital expenditures, there is cited H.R. 13080, the Medicare-Medicaid Administrative and Reimbursement Reform Act (S. 3205, in the Senate). In that bill, Section 10, pertaining to changing the methods of determining reasonable cost of services provided by hospitals, and Section 11, pertaining to inclusion in reasonable cost of hospital service of an allowance for retirement or conversion of underutilized facilities, are the two areas pertaining to hospital reimbursement which the bill addresses.

In Section 10 of the bill we are deeply concerned that the quality of patient care will be sacrificed to the proposed methodology in that section for the determination of reimbursable hospital cost. Under such methodology a hospital could be paid more or less than its actual costs, depending on the relationship of its actual costs to average costs for its hospital classification. Formula determinations for hospital reimbursement would not be operative as a guide to the reasonableness of each hospital's costs; they would constitute restrictions, based on statistics, on the reimbursement of costs to a hospital, whose actual costs might be in excess of the average for its classification.

Section 10 would establish a uniform system of accounts and cost reporting for hospitals in arriving at operational costs. All hospitals would be categorized according to size, type of hospital, and such other criteria as the Secretary might select. The routine operating costs would be determined, according to hospital classification, by averaging the costs of all hospitals in a category and adjusting for price increase percentage. For hospitals whose actual operating costs exceeded the average, payment could not exceed 120 percent of the adjusted average per diem poyment rate for such hospital. Hospitals with below-average operating costs could receive an incentive allowance. Special provisions would provide exemptions for hospital "hardship cases", and cost adjustments could be made for certain hospitals in underserved areas and for hospitals which have an unusual case mix.

Reimbursement ceilings for individual hospitals, as set by Section 10, are not based on an actual assessment of what it costs to provide hospital services. The leeway permitted hospitals whose actual costs are above average, the special allowance for those which are below average, and any special consideration for hospitals which are understaffed or which have special cost problems or serve needy areas are commendable. But clearly, as an end result, the payment of actual and necessary costs of providing hospital care is no longer the controlling factor; instead a system is created for setting arbitrary statistical limits on hospital reimbursement.

The proposal provides no assurance that inefficiency will be corrected. The prescribed methodology simply creates a pressure to reduce costs to a set dollar amount without regard to how such reductions may be attained. If a hospital is forced to treat Medicare and Medicaid beneficiaries at a loss, its ability to retain needed employees and to maintain a level of expenditures necessary to provide quality services will be reduced. This in turn will lead to reduction of the range of services available from a given provider and will significantly alter the quality of patient care. Moreover, failure by Medicare and Medicaid to compensate a hospital for its actual costs can only result in additional inequitable shifting of program costs to private patients in further violation of statutory proscriptions in the Medicare law.

We recommend that an approach such as that found in Section 10 of H.R. 13080 not be adopted. Medicare and Medicaid are represented to provide health care in the mainstream for their beneficiaries. The federal government must meet this commitment. We cannot subscribe to, nor condone, "average" health care services for our elderly and disadvantaged in order to accommodate payment "on the average".

On the other hand, Section 11 would authorize increased payments from Medicare, Medicaid and Maternal and Child Health Care funds to cover a "reimbursement detriment" as a result of a qualified conversion or closure of underutilized facilities. This would authorize an increase in payment as recommended by a national board and finally determined by the Secretary, when such conversion or closure resulted in a reduction in capital-related reimbursement or in costs above those reimbursable under the "reasonable cost" determination formula.

We support the principle of providing assistance to hospitals which would suffer a "reimbursement detriment" as a result of voluntary conversion or closure of facilities which are underutilized and for which adequate alternative sources of care are available in the area. This could encourage a more effective use of hospital facilities. Initiating this support on a limited basis, as provided in the bill (for 50 hospitals), will enable an assessment to be made of this mechanism before more widespread application is attempted. We view this innovation as an experimental program.

We do have some reservations concerning the use of Social Security health care funds for a program of assistance for the conversion or closure of facilities. In effect this would be devoting Social Security health care funds for other than direct health services. In our view, funding for the conversion or closure of facilities might more properly be provided from other sources.

We also note that several alternative types of reimbursement to hospitals are suggested in the Committee notice. There is no other specific legislation cited in the notice. We believe there is benefit in experimentation. The AMA supports the undertaking of alternative, experimental programs for hospital reimbursement under Social Security programs including Medicare, Medicaid and Maternal and Child Health.

We supported the provisions presently in the Medicare law, Section 22 of Public Law 92-603 authorizing experimental programs. That section would allow the Secretary of HEW through contracts and grants with public or private agencies or organizations to "develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of various alternative methods of making payment on a prospective basis to hospitals . . ., for establishing prospective rates of payment, and for implementing on a gradual, selective, or other basis the establishment of a prospective payment system. . . ."

We believe that this is full and sufficient authority to carry out experimental programs for reimbursement of hospitals. We believe that the intent of this section of P.L. 92-603 was to develop data relative to alternative types of reimbursement. Congress should not initiate new and extensively changed programs for reimbursement for Medicare and Medicaid in the absence of demonstrable experimental programs indicating appropriate alternatives and the effects such alternatives may have on all patients, both private and public.

As we stated earlier in our statement, hasty changes in reimbursement have effects on all patients and not just on beneficiaries of federal programs. We would, therefore, urge that this Subcommittee investigate the extent of implementation of the experimental authority of HEW in various programs, and evaluate the effects of those programs, and urge that additional programs be implemented utilizing other experimental reimbursement methods prior to consideration of the far ranging changes implied in the present hearing.

We urge that any substantial change in reimbursement be founded upon satisfactory experimentation so as not to put in jeopardy the quality and accessibility of care.

The AMA offers its assistance to the Subcommittee in evaluating any experimental program presently under way and any other program which would appropriately be initiated on an experimental basis pursuant to the authority of Section 222 of Public Law 92-603.

Sincerely,

JAMES H. SAMMONS, M.D.,
Executive Vice President.

STATEMENT OF MICHAEL F. DOODY, PRESIDENT OF THE AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

The AOHA maintains its Headquarters in Park Ridge, Illinois, with an Office in Washington, D.C., and represents the osteopathic hospitals throughout the country. Osteopathic hospitals, which number 204 in total, are located in 28 states. These institutions serve as the primary institutional care facilities for those patients (individual consumers) who choose to receive their health care from one of the approximately 15,000 practicing osteopathic physicians in the country.

Osteopathic physicians represents a second school of medicine. The osteopathic profession is a politically and philosophically separate and administratively independent school of medical practice. Osteopathic physicians represent approximately 5 percent of all physicians in the United States, but it has been estimated they care for as much as 10 percent of the United States citizenship.

The 204 osteopathic hospitals represent more than 23,000 inpatient beds and employ 60,185 people. In 1975 osteopathic hospitals had more than $900 million in total expenses while providing health care services for more than 800,000 inpatient admissions and 2.8 million outpatient visits.

Osteopathic institutions and physicians are interested in the delivery of quality health care and for the most part are providers who concentrate in the areas of general practice and family medicine. Approximately 70 percent of all practicing osteopathic physicians are general practitioners or specialize in primary care areas (internal medicine, family practice, pediatrics, obstetrics-gynecology, general surgery). Osteopathic hospitals are cost conscious institutions whose primary objective is the delivery of quality health care.

Osteopathic hospitals represent an important community health resource. Many of our hospitals are located in rural or semi-rural areas and provide a very necessary community health service. In some instances, the osteopathic hospital is the only hospital present within a community.

INTRODUCTION

Osteopathic hospitals have taken action to contain costs. Our hospitals have taken a variety of cost-cutting steps such as mergers, shared services, the development of ambulatory care programs, cost containment reviews and many other internal management programs. In addition there are a number of governmental and voluntary controls in existence such as the accrediation procedures, reimbursement controls, certification of need for facilities and services, that are all directed at this same issue.

The amounts hospitals must pay to meet operating expenses has risen steadily over the past several years. The major components of the rising costs include such things as energy, food, premiums for malpractice insurance and labor costs. The hospital market basket is becoming increasingly more expensive. And that market basket is a considerably higher priced market basket than the Consumer Price Index (CPI) market basket. Hospitals buy an extraordinary amount of utilities and petroleum-related or petroleum-base products. At the same time hospitals are not producing a uniform product such as the steel industry or the meat packing or other industries produce. The hospital product, a patient day of quality health care, is an extremely complex item to produce and it is a product that is constantly changing and improving. Government regulations, program requirements, and accreditation programs all aimed at improving quality also have significant financial implications. Improvements in care—for example intensive care units, ambulatory and emergency services and other innovative procedures, the declining length of hospital stays and treatment with more complex diagnoses—have all contributed to the change and improvement of the product, but have also contributed to increased per unit costs. Finally, a highly trained, very specialized labor force requires considerable higher rates of compensation.

National health policy necessary

Before the Congress enacts new measures which tinker with the health care system, we would respectfully suggest that a national health policy be developed against which any further changes in the system can be evaluated. A national policy must be established and goals set to allow the Congress and the health care delivery system to understand what it is this country wants in the way of a health care system. Once that is accomplished, decisions can be made by those responsible to determine how much and what kind of health care we as a nation are willing and able to afford.

Once we as a country have agreed upon what we expect our health care system to accomplish and how much of our national resources we are willing to devote to health care, decisions on how the system must respond will be able to be made more quickly with unanimity of thought.

The quality of health care

One of the few unassailable facts concerning the issue of health care costs and their increases is that the major goal of this nation's health care delivery system is the provision of quality care to all Americans who seek it. This is the cornerstone of the entire system.

Another point on which we can agree is that we cannot sacrifice quality to save dollars. By the same token, we cannot use quality as an excuse to write a blank check for the cost of medical care. It is vitally important that high quality and cost efficiency go hand-in-hand, and we therefore recommend that incentives be provided for those institutions which maintain high quality and which prove to be efficient in the delivery of health care.

Every successful company must choose from time to time between advancing quality and improving profitability. Unless there is a dominant market factor, quality in such a decision must almost inevitably come out the loser. The hospital, on the other hand, would have to be in desperate straits before it could even consider economizing on its sole stock and trade—patient care. The same public that accepts the inevitability of flawed merchandise in a department store has a way of demanding flawlessness in doctors and hospitals. This is a form of public expectation and respect with which the health care industry must live.

Effect of inflation

First, and foremost hospitals do not cause inflation. Virtually all hospitals operate on tight budgets and quickly fall victim to rising costs.

Second, hospitals are labor intensive. They are staffed 24 hours a day, 7 days a week. More than 50% of the hospital dollar goes to salaries, wages and fringes. Third, hospital budgets are constantly jilted by new facilities and procedures that are expensive to equip and sometimes even more expensive to man.

Fourth, hospitals all over the country provide care for millions of people who cannot pay. The penniless customer can be denied a 50¢ loaf of bread but not a $1,000 surgical procedure. Fifth, the hospital customer, unlike other customers, almost never shops price. Once the decision has been made as to the kind of room he will occupy, he demands nothing less than the best the industry and its sciences can offer, even miracles. There is no patient demand for a cheaper model. And it must be remembered it is the physician—in consultation with the patient and his family—not the hospital, who decides what tests, treatments, and other procedures will be utilized.

The cost of hospital care has indeed risen spectacularly. 1500 percent if you go back 40 years, 150 percent if you go back 10. It is commonly stated that the cost of hospital care has risen over the course of the past 10 years at a far faster rate than the overall rate of inflation or the Consumer Price Index. However, these figures fail to adequately identify the fact that a patient day of care in 1976 is a far different product than a patient day of care in 1966.

Prestige life-saving equipment that so many of us have insisted our community hospitals obtain in order that we and our families can be assured of the most up-to-date adequate high-quality health care services is very expensive. In the past 8–10 years more and better-trained personnel are devoting their talents to producing a patient day of care in the hospital. More and better nonlabor items now go into a patient day of care—i.e., hospitals perform a greater variety of tests with greater sophistication today than in the past. Equipment such as thermography machines, renal dialysis, nuclear scanning equipment, etc., are common today whereas 10 years ago they were engineering sketches at best.

We believe it is highly inappropriate to attribute the influence of increased use of personnel and supply input to a price rise. If a family switches from eating brisket to steak, no one would attribute all of the rise in their food cost to price increases; yet this is the equivalent of what occurs when all increases in hospital unit costs are attributed to price increases.

We strongly believe that it would be appropriate and equitable for this Subcommittee to consider the fact that a portion of the hospital service charge represents improvements in services and new technology.

The common guidelines for determining hospital costs are cost per day and average length of stay for the patient. Comparable statistics such as these are very misleading to everyone. Making regional or even intercommunity comparisons of this kind are arduous and highly involved. Guidelines such as cost per day and average length of stay, which have lead to over simplified public disclosures and the tendency to play leap frog with intricate logic and history, become useless when you come face to face with the real world.

For example, Cleveland hospital costs are higher than those of Columbus, simply because Cleveland is a higher cost of living than Columbus. Labor, that 50+% factor in hospital economics, costs more in Cleveland than Columbus as does most of what hospitals buy. That fact, in and of itself, does not fully explain the differences but it is a valid fact, a starting point.

Malpractice premiums, energy, and labor costs

The potential impact of malpractice premium increases upon hospital charges is of serious concern. Malpractice insurance is another example of the complex, highly expensive hospital market basket. While general liability insurance used to amount to something less than $1 per patient day on the average, it is now not unusual that the cost per patient day for general and professional liability ranges anywhere from $3 to $8 in the hospital. One example of the horrendous impact the malpractice crisis is having on hospitals is one of our 130-bed hospitals in the Midwest. In 1974–75, the hospital's general and professional liability premium was approximately $55,000 for a $500,000–$1,500,000 coverage with a $3,000,000 umbrella. This appears to be a reasonable and not excessive amount of coverage. In 1975–76—despite the fact that in the past 10 years the hospital has not had a major suit and has paid out only $6,000 in claims—the hospital has had tremendous difficulty in finding a company to write the same level of coverage. Finally, the hospital was able to find several companies to write a package equal to last year's coverage at an annual premium of $201,493.

This subcommittee is well aware of the significant impact the malpractice insurance crisis has had on hospital costs, as well as on the health consumer, the insurance industry, and the public as a whole. It is important that you understand that increased premiums and the defensive practice of medicine resulting from this crisis are adding millions of dollars each year to this nation's health care bill.

Hospitals use energy in considerable quantities. Electricity is used for powering delicate and sensitive devices and machinery, lighting, heating, and cooling. Petroleum products help provide this electricity and are used for countless plastic products such as tubing, containers for blood, eating utensils, sutures, etc. This Subcommittee is aware of the costs of energy but we suggest that a closer look be taken at the uncontrollable effects energy has on the costs of delivering health care.

The greatest single expense of running a hospital is personnel and an employee benefits program. It is also the least understood. Today industrial efficiency is measured by an ability to produce more with fewer workers and by that measurement hospitals may seem industrially inefficient.

Hospitals which employed an average of 2 employees per occupied bed 25 years ago, today employ between 2.6 and 3.0 and even more in specialty areas. If one assumes that hospitals have the same opportunities as other industries and simply fail to make use of them, the statistics on hospital labor intensity must be confusing.

Two points must be made for realistic appraisal of the hospital labor picture. One, hospitals never stop trying to find new labor-saving methods and facilities. In some functions they have made dramatic, effective innovations. But too many key jobs in hospitals can only be done by human hand. While mechanical innovations scale down the man hours needed for a given piece of work in a factory, new machinery in a hospital may require more people with greater cost for labor skill. For example, open heart surgery requires the basic $50,000 surgical unit, a $35,000 heart-lung machine, and $100,000 a year for special personnel to maintain and monitor the instruments.

The patient demands the best the industry can offer, and the industry has a moral obligation to provide the best possible health care. When a new diagnostic or therapeutic technique becomes available, the basis for determining its viability is its contribution to faster and more accurate diagnosis and therapy. Cost is a factor, but it is a secondary one. As has been stated previously, quality cannot be sacrificed for efficiency. We are talking about medical care—the saving of lives and treatment of sickness and injury—not saving dollars. There can be no comparison or compromise on this point. That the system needs alteration and that it can be streamlined toward greater efficiency is certainly a valid fact. But we cannot do this and at the same time halt scientific progress and its development of new, life-saving machines and instruments.

There are many areas where hospitals are saving money and cutting costs for labor. These include food service, housekeeping, laboratory work, film processing, delivery of medication, and so on. New machines, for example, can make 200 blood tests in the time it used to take for 1, with no loss of accuracy. In addition, hospitals do many things cooperatively that would be impossible in industries where competitive secrecy prevails and where too much cooperation might be cited as being in restraint of trade.

Another unchangeable fact of hospital life is the need to remain open and competently staffed every hour of every day. A hospital job is not 8 hours a day but 24, not 40 hours a week, but 168. Add considerations such as sick time, vacation and holidays and you realize that it takes 5 people to cover one job in a hospital.

In considering the productivity of the hospital worker, we have to realize that the average employee of any health care institution is busier now than he or she ever was. When the employee-to-patient ratio was 2:1 some decades ago, hospital employees worked 2 daily 12-hour shifts instead of today's 3 8-hour shifts. Hospital pay was very low. The competitive wage catch-up has had a marked affect on hospital costs over recent years.

The effect of controls

It is a common myth that the imposition of economic stabilization controls on hospitals affected the inefficient more than it did the efficiently operated institutions. The fact of the matter was that the effect was just the opposite. The better-managed hospital was more adversely impacted by the controls. This occurred for two reasons. Arbitrary controls were aimed at forcing every hospital to improve upon its operational performance by comparing succeeding years with a base line year. If the base year had been highly successful in a financial sense, the hospital was less affected than a comparable one that might be serving an inner city population and running at a deficit. The controls discriminated against hospitals which had been well managed for years. Since it was assumed that all hospitals had a considerable distance to go to improve efficiency, application of uniform controls hit the well-managed ones the hardest. Over the years, they had trimmed the fat in their budgets. When forced to the wall, these hospitals had to cut back on service, lower their quality standards, defer expenditures for needed capital equipment, or maintain cash flow by pumping money allocated to depreciation reserves into operations.

Hospitals that were previously inefficient found that they could do some trimming of their payroll and other areas of operation which were not at peak efficiency. Arbitrary cost control measures—particularly if not imposed upon the entire economy—tend to have unequal and inequitable effects on hospitals.

S. 3205/H.R. 13080

This Association agrees completely with the basic premises which prompted the introduction of S. 3205 and H.R. 13080—we cannot continue with a program which increases in costs faster than the rate of rise in federal revenues; we must make Medicare and Medicaid more efficient and economical or benefits will have to be ultimately reduced; we must avoid arbitrary controls on payments to hospitals; we must provide incentive payments to encourage efficiency; and finally, such changes must be made prior to any expansion of the federal role in providing more health insurance to more people since without such changes any expansion would be an open invitation of fiscal disaster.

The American Osteopathic Hospital Association and its member hospitals have long supported efforts to overhaul the present hospital reimbursement system. We believe that the present practice of grouping hospitals according to bed size and geographic area should be altered to include such other factors as patient mix, level and scope of services, labor costs, and the extent of teaching programs. In addition we have often advocated the undertaking of a positive program to develop incentives for hospitals to participate in programs which have proved themselves to be effective in containing hospital costs, including prospective payment systems.

Under the present system, if two hospitals of similar bed size in the same geographc area have a variation in costs, at least one is assumed to be inefficient and have poor management and unreasonable costs. This is a premise which we cannot accept. Variation in costs between hospitals is not indicative of poor management or inefficiency. Other factors, recognized in S. 3205 and H.R. 13080, contribute to and affect the efficient delivery and cost of hospital and health services. This Association supports government efforts to reduce reimbursement to institutions where it can be shown that costs are unreasonable and the result of marked inefficiencies in operation or conditions of excessive services. We are in sympathy with the concern expressed by the Senate Finance Committee in its report on the Social Security amendments of 1972: ". . . when the high costs (from hospitals) flow from inefficiency in the delivery of needed health services the institution should not be shielded from the economic consequences of its inefficiency." The determination of what is "reasonably prudent and cost-conscious management" is the issue at controversy. It is this issue which S. 3205 attempts to address, and it is this issue on which we will briefly comment. It must be remembered that the remarks we shall set forth are directed at achieving one common goal: that of providing the best possible health care and a cost-effective well-organized system for the American people.

Section 4, State medicaid administration

From the point of view of the delivery of health care, and to the extent that the language improves the Medicaid program and saves money, this Association supports Section 4. We are particularly supportive of the incentive approach, both here and in the Medicare program, which rewards hospital efficiency. We have long advocated that the Medicaid program should be federalized and contracted to private insurers for administration. The unevenness of Medicaid benefits and reimbursements among the states can only be leveled through the intervention of the federal government. The present situation does not consider the critical problems in state financing, and decreases the viability of the existing program and its scope and levels of coverage.

Section 10, improved methods for determining reasonable cost of services provided by hospitals

This section of the legislation is indeed far-reaching and the most significant for hospitals. We applaud the insight and attempts to develop an effective hospital reimbursement system. While any classification system for hospitals is by its very nature arbitrary, the proposed new method of reimbursement for routine operating costs for hospitals embodied in this legislation seems to us to be a major step forward in the development of an equitable system. Of all of the proposals made to date, this appears to this Association to be one of the fairest yet devised, and it is certainly vastly better than the classification system presently in place. We are particularly pleased to see the exclusion of variable cost elements such as educational and training costs, and energy costs.

We would also urge consideration of including other variable cost elements such as malpractice insurance premiums; the cost impact of government-mandated programs such as health planning, PSRO's, and utilization review; and charity care losses. Each of these areas contributes heavily to hospital costs and does so more heavily in some areas than others. Adjustment of routine operating costs to take into account the effect of area wage differences is also an important factor. We would also urge that the cost of an employee benefits package be included when calculating the effect of area wage differences. This Subcommittee is most aware of the fact that these packages vary widely in scope and cost and that they can have a significant impact on cost.

We are not convinced, however, that any classification system is appropriate for the purpose of identifying institutions whose costs are "unreasonable". A more appropriate use of the classification system might be to identify those hospitals whose costs need more careful review to determine the reason for the "high costs" and to evaluate whether or not, given the hospital's individual circumstances (i.e., size, location, patient mix, services offered, etc.), the costs are excessive or unreasonable.

Malpractice premiums are a major contributing factor to rising hospital costs. Therefore, we recommend that provision be made to accept the hospital's general and professional liability (malpractice) insurance premium as an allowable cost or as an adjustment in the routine operating costs similar to that allowed for the effect of area wages and benefits.

Routine operating costs in S. 3205 and H.R. 13080 does not include "energy costs associated with heating or cooling the hospital plant." This Association questions the limitation of this provision to just heating and cooling. Hospitals use enormous amounts of energy, particularly electricity, over and above those amounts used for heating and cooling. We would strongly recommend consideration of a hospital's true, overall energy consumption, not just that portion devoted to heating and cooling.

This Association supports the application of this Section to Medicaid as well as Medicare as a welcome step toward federalizing Medicaid. We are concerned, however, that the actual language of the legislation is not specific enough to assure state acceptance of and participation in the proposed classification and reimbursement systems. We believe it is essential that the legislation mandate full compliance with the proposed new systems as a condition of state participation in the Medicaid program.

As mentioned previously, this Association favors the incentive approach—rewarding hospitals whose comparable routine operating costs are less than the mean and penalizing those whose costs are substantially above the mean. The three-year phase-in approach will certainly give hospitals time to adjust and we commend the Chairman for his foresight in establishing this concept.

We are somewhat concerned about the system of classification of small hospitals, those in the 5- to 24-bed category, and those in the 25- to 49-bed classification category. Many hospitals in these categories are located in rural or semi-rural areas and compliance with federal regulations is often very difficult for these institutions. Attempts to comply with HEW regulations in order to get the federal funds, which many of these rural health facilities find necessary to remain solvent, have resulted in great expense and in some cases closure of the facility altogether. Despite some HEW attempts in certification of access hospitals, it became apparent in the early 1970's that some rural hospials were having difficulty complying with nursing staff requirements and other regulations.

HEW is not eager to make provision for the problems of these small rural hospitals and therefore such guidance will probably come only through an amendment to the Medicare regulations. Such amendments would have to create a new classification for rural hospitals. One attempt to do this is House Bill H.R. 13267 and we are sure others have addressed the issue as well. We recommend that this Subcommittee consider this problem, and attempt to make some provision in the categories of classification which would recognize the inherent problems faced in rural areas.

We believe the appeals mechanism provided to those hospitals penalized as a result of the hospital falling outside the parameters of the classification system is unrealistic, inequitable, and designed to prevent the hospital being able to effectively defend itself. It is virtually impossible for a single institution to identify all the hospitals in its classification cell, and then to undertake a proper study to compare and contrast its patient mix, utilization, and cost statistics with all the other hospitals in that cell.

One of our member hospitals, which is owned by a college of osteopathic medicine and which is located in rural Missouri, has been trying to appeal such a decision for the past 6–8 months, at great expense to the institution. The futility of the hospital's effort was evident from the beginning and points up the enormous inequity and unreasonableness of the proposed appeals process.

Finally, in our reading of Section 10, we detected an apparent drafting error in Section 1861(a)(3)(D)(ii). As presently worded, a portion of this section reads ". . . as determined by the Joint Commission on Accreditation of Hospitals, state ageny certification procedures, or any other findings or information available to the Secretary."

As the members of this Subcommittee are aware, the osteopathic profession is a second school of medicine, recognized as such and supported by every major federal health care program. The Medicare program recognizes the American Osteopathic Association as the accrediting agency for osteopathic hospitals. We therefore recommend that this section of S. 3205 be amended by inserting after the words "Joint Commission on Accreditation of Hospitals," the words "the American Osteopathic Association,".

Section 30, reimbursement rates under medicaid for skilled nursing and intermediate care facilities

We find the current three-day hospitalization requirement in Section 1861(i) to be unnecessary and unfair to the patient, and it requires, in some instances, unnecessary utilization of the acute care facilities of the hospital when readmission to an extended care facility would be in the better interests of the patient.

Under present law, a patient can only be admitted to a skilled nursing facility or intermediate care facility, and be covered under Medicare, if he or she has been admitted to a hospital as an inpatient and stays for a period of at least three (3) consecutive days. In addition, if after the patient is admitted to an extended care facility, is treated, and released and it is later determined that re-admission to the facility is warranted, the patient must again be admitted as an inpatient in a hospital for three additional days.

We recommend inclusion in this Section of an amendment to Title XVIII of the Social Security Act, Part C, Section 1861(i), which would strike the words "in which he was an inpatient for not less than three consecutive days before his discharge from the hospital in connection with such transfer". The first sentence of Section 1861(i) would then read as follows: "The term 'post-hospital extended care services' means extended care services furnished an individual after transfer from a hospital."

We also recommend that this Committee consider the possibility of drafting a change in the statute which would provide for direct admission to an extended care facility upon proper certification by a physician. Of course we recognize the need for safeguards to prevent abuse, but we feel the best interests of the patient and the hospital would be served by such an amendment.

SUMMARY AND CONCLUSIONS

Several vitally important points can be made with respect to the cost of health care delivery. First, the public has come to expect high quality health care services which are expensive. Second, the cost components of delivering those services are very complex and partially uncontrollable by the hospitals responsible for delivering the services. Third, hospitals are making sincere and substantial efforts to control costs. Fourth, health care costs will continue to rise whenever the components of that cost rise. Fifth, hospitals are not the creators of inflation, they are the victims. Sixth, hospitals do not produce a uniform product, but must deal with individual patients with individual needs and problems.

The American Osteopathic Hospital Association recommends that this Subcommittee seriously consider all of the components of the rising costs of health care delivery by hospitals. We believe that development of a sound national health policy should precede enactment of any new measures which alter the health care system. This process will result in the delivery of high quality medical care to every American and also result in keeping costs from rising so rapidly.

A number of proposals have been offered which impose a percentage limitation on the reimbursement of hospital costs. Such alternatives are by their very nature arbitrary and result in unequal and inequitable consequences. The inefficient institution is rewarded, and the efficient, cost-conscious institution is penalized.

The reward system is reversed, incentives for economy are lost, and oftentimes it is the patient who suffers. The hospital reimbursement proposal embodied in S. 3205 and H.R. 13080 avoids this pitfall, and while any classification system for hospitals is by its very nature arbitrary, the one set forth in this legislative proposal is one of the fairest we have seen to date, and could be improved with the changes we have recommended.

There is a need to devise new financial mechanisms that will encourage efficient management of our resources and contain rising costs without, at the same time, impairing the capacity of the health care system to meet our patients' needs. By and large most current proposals fail substantially to address this issue. S. 3205 and H.R. 13080 are a major effort in the right direction, but we urge this Subcommittee and the Congress to take more definitive action to move away from cost-based reimbursement and into programs utilizing state-level prospective rating systems.

The hospital industry has provided several recommendations and suggestions for bold and innovative prospective financing systems which move away from reasonable cost reimbursement but which take into account hospitals' full financial requirements. We urge your consideration of these proposals.

Osteopathic hospitals are very much aware of the need for a more rational mechanism to allocate and use our limited health resources. However, as the Director of the Congressional Budget Office, Alic Rivlin, recently said, controls must deal with:

"... problems of achieving cost equity between types of services, provider and beneficiary groups; of redistributing care to areas of greatest need; of guiding the development of cost-efficient new delivery systems which are acceptable to providers and consumers; ... the feasibility of administering a complex system of incentives and controls ... which can restrain inflation and wasteful expenditures without at the same time curtailing desirable improvements in the quality of health services and imposing undesirable rigidities on the delivery system."

This is a difficult task at best. The proposals we have set forth in this testimony are an attempt to deal with each of the issues mentioned in an equitable manner for all concerned.

Congress of the United States,
House of Representatives,
Washington, D.C., August 3, 1976.

Hon. Dan Rostenkowski,
Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: I greatly appreciate this opportunity to propose for your subcommittee's consideration a solution to the problem of rising hospital costs during its deliberation of this issue.

The solution to this problem, in my opinion, lies in the expanded use of physician extenders (nurse practicioners, physicians' assistants, and "Medex") in situations where a physician cannot always be present. Physician extenders provide readily available primary health care which keeps people well and out of hospitals. I believe that reimbursement under Medicare is of primary importance in order to ensure the continued use and expansion of physician extenders' services.

Physician extender programs have been in operation for over a decade and experience during that time has shown that clinics managed by these professionals are the best solution to the chronic problems of access and cost for underserved rural and urban areas of this Nation. Moreover, study after study has shown that—not only does health service improve with the use of these clinics—but total medical costs, including Medicare costs, actually decrease.

All of the reliable studies conducted on a first-hand basis lead to the conclusion that the use of physician extenders in primary health care clinics lower total hospital costs significantly:

A STUDY OF DIABETES

A study of diabetes mellitus sponsored by the Department of Health, Education, and Welfare, the Public Health Service and the National Institutes of Health and conducted by the Fogarty International Center this year, made some remarkable findings. In the study, 555 diabetics were transferred from city hospital clinics to decentralized, physician extender-staffed clinics for maintenance care. The results were impressive: the cost of ambulant care received in the decentralized locations was one-fifth the cost of comparable care rendered in medical center facilities. A visit to a neighborhood clinic cost $4 compared to $20 for a hospital outpatient visit and $35 for an emergency ward visit. When the pattern of hospitalization for the two year period before and after transfer was examined, a 49 percent reduction in hospital days and a 42 percent reduction in hospital discharges were found. There was an approximate reduction of 44 percent in the cost of continuing care as compared to the cost by conventional methods used before the transfer to physician extender-staffed clinics. ("Improving the Organization of Care for the Chronically Ill," *Diabetes Mellitus*, Fogarty International Center Series on Preventive Medicine, Vol. 4, 1976.)

DIABETES, HYPERTENSION, CARDIAC DISEASE

In another study conducted by John W. Runyan, Jr., M.D. and reported in the "Journal of the American Medical Association," similar results were found for those sick with diabetes, hypertension, and cardiac disease. The change in the number of hospital days for diabetics declined 49.4 percent; for those with hypertension, a decline of 52.3 percent was found; and for those with cardiac disease, a decline of 49.3 percent was evidenced. Patients with these diseases who continued to be treated at hospital clinics experienced an increase in hospital days over the same period of 43.0 percent.

What should be of particular interest is the fact that those of Medicare age—those over 60—experienced a decline in total hospital days of 52.7 percent under the care of physician extender-staffed clinics. ("The Memphis Chronic Disease Program; Comparisons in Outcome and the Nurses' Extended Role", JAMA, January 20, 1975.).

FRONTIER NURSING SERVICE EXPERIENCE

A study by Karen Gordon of Yale University School of Public Health, and Gertrude Isaacs of the Frontier Nursing Service, Heyden, Kentucky, indicated that 239 diabetic patients using nurse practitioner clinics averaged 41 percent fewer hospital days than the national average for these types of patients—or a savings of 3.2 days per patient per year. A spokesman for the Frontier Nursing Service has also testified that their patients over age 65 had 70 percent fewer hospitalizations than other elderly patients from neighboring communities without physician extenders. (Mr. Harry Teter, Jr., Executive Director, Appalachian Regional Commission and Ms. Gertrude Isaacs, Sc.D., Testimony before the House Ways and Means Subcommittee on Health, Knoxville, Tennessee, July 22–23, 1976.).

APPALACHIAN REGIONAL COMMISSION CLINICS

A survey of the 200 Appalachian Commission clinics which serve thirteen States showed that 12 to 25 percent of their 300,000 users would have been hospitalized were the clinics not available. Moreover, the average patient visit in A.R.C. clinics cost only $14. Physician reasonable charge reimbursement, according to the Social Security Administration, ranged from $12 to $22 for the same service in F.Y. 1975. (Mr. Harry Teter, Jr., Testimony before the House Ways and Means Subcommittee on Health, July 22–23, 1976.).

What would explain the astonishing decrease in hospitalization and its resultant costs? The answer seems clear. Several factors were introduced to the group which was treated by physician extenders rather than by hospital staff:

First, professional care and advice are easier for the patients to obtain when the rigid appointment system characteristic of the hospital clinic is removed.

Second, patients are given the opportunity to call the clinics if in need of medical assistance, and appropriate advice is given or home visits are made.

Third, the same medical protocols and opportunities to obtain selected laboratory tests prevail whether the patient is seen in the decentralized clinic or at home.

Fourth, missed appointments are followed up by clinic staff.

Fifth, drugs are actually dispensed directly to the patient while being seen by the physician extender. This creates the opportunity for patient education and counseling and it is thought that patient compliance is greatly enhanced as a result.

The Federal Government has not been oblivious to the valuable role played by physician extenders. The Bureau of Health Manpower of the Department of Health, Education and Welfare is already spending in excess of $15 million per year to train physician extenders. The approximately 2,800 graduates now receive an annual salary of between $12,000 and $25,000—and many of these receive part or all of it from Federal programs or grants. The Federal government has made a commitment to physician extenders yet the absurdity is that another arm of the government does not think that the services are valuable enough to qualify for reimbursement under Medicare when rendered in physician extender-staffed clinics! This is in spite of the fact that these professionals have shown that they can save the Medicare system many times the estimated $10 million per year it would take to reimburse them under Medicare.

In order to correct this incongruity, I introduced legislation in May of 1975 which would allow for the reimbursement of physician extenders for Medicare eligible services rendered when a physician was not physically present. More recently, as you know, Congressman James Symington introduced a similar bill and on the Senate side, Senators Pearson and Huddleston have introduced legislation which would remedy the situation.

It is my hope, Mr. Chairman, that during your subcommittee's deliberation of how best to control rising hospital costs, you will give close and serious study to the outstanding work done by our nation's physician extenders. They have proven their value to the patient and to the Medicare system.

With best regards,

JAMES T. BROYHILL,
Member of Congress.

EMERYVILLE, CALIF., *August 1, 1976.*

SUBCOMMITTEE ON HEALTH,
Committee on Ways and Means,
Longworth House Office Building, Washington, D.C.

DEAR SIRS: Although I am unable to attend your hearing on August 3rd relative to revisions in the Medicare Hospital Reimbursement System, I would like to present my viewpoints relative to issues 4 and 9 as specified in your press release.

4. PROSPECTIVE RATE SETTING

(a) This approach is far more desirable than the cost reimbursement formulae now in effect because, if designed properly, it can allow for cost containment incentives without reducing the quality of patient care below a reasonable level.

(b) The approval of prospective rates should probably be done at a State level and, in states like California having significant cost difference within the State, at regional levels within the State. I believe this function should not be done at the Federal level because of the wide diversity of costs and other health care considerations in various parts of the country. It is totally impractical to do it at the Federal level.

(c) The rates should be set on a per diem basis separately for each level of basic nursing care. This means separate rates would be established for Medical/Surgical Care, Intensive Care, Coronary Care, Nursery, Pediatrics, Burn Centers, Alcoholic Care Units, etc.

This is *very important* to recognize changes in mix between these centers occurring in actual services rendered as compared to anticipated services considered in rate-setting. One of the inherent fallicies in many of the State overall per diem limitations (and the 7% limitation proposed by President Ford) is that the overall approach ignores these differences. Consider the following example (admittedly over-simplified but illustrative of the problem). The example assumes that the rate was based on anticipated costs:

	Days	Rate per day	Total
Budget:			
Medical/surgical care	16,000	$115	$1,840,000
Intensive care	1,000	275	275,000
Coronary care	800	270	216,000
Nursery	3,000	65	195,000
Total	20,800		2,526,000
Overall rate ($2,526,000 divided by 20,800)	$121.44		
Actual payments: 20,800 days times $121.44	$2,525,952		
	Days	Cost	Total
Actual services rendered and costs:			
Medical/surgical care	15,800	$115	$1,817,000
Intensive care	1,200	275	330,000
Coronary care	1,000	270	270,000
Nursery	2,800	65	182,000
Total	20,800		2,599,000

In this example, the hospital kept its costs on the budget figure but, because of a swing in mix, was under-paid $73,048 ($2,599,000–$2,525,952). It could just as easily go the other way.

As to ancillary services such as X-rays and lab tests, rates should be set separately from the rates described above for basic nursing services because the volume of such services rendered by a hospital is determined by physicians and is not controllable by hospitals. It would probably be impractical to set a rate for each separate procedure because there are hundreds of them. Rather it might be more practical to set a rate per procedure for each department, or perhaps a rate for designated types of procedures within departments such that, for example, there might be five rates for five broad categories of laboratory tests. This matter needs more study.

(d) The rates approved for any given hospital should apply to all patients serviced by the hospital without regard to who is paying the bill, whether it be an insurance company, a governmental program or private patient.

(e) The approved rates should encompass *all* reasonable budgeted costs of the institution involved. Here I refer primarily to bad debts and charity care for underprivileged patients who, for some reason or another, do not qualify for Medicaid. Medicare and Medicaid have always taken the position that these costs relate to non-program patients and therefore the program does not pay these costs. This reasoning is peculiar to these programs and contrary to universal business practice wherein charges are set to cover such costs. For example, when any one of you buys something in a retail store, you are aware that the prices include a factor to cover the costs associated with shoplifting as well as bad debts. I presume that members of the subcommittee are not shoplifters and that you pay your bills, but I submit that you acknowledge the necessity of having to pay a little more to make up for these elements of a store's costs. A hospital is no different. It incurs bad debts and charity work in amounts that vary widely depending on whether the hospital is in a rich or poor neighborhood.

One other matter here. The Medicare and Mediaid programs have taken the position that costs associated with patient telephones and televisions are not "reasonable" costs. I think that may have been true in 1930, but I believe the programs should recognize that times have changed and these are normal necessities now which may contribute to lower lengths of stay because of the psychologically beneficial effects on patients.

(f) Retroactive adjustments should be kept to a minimum and be based upon extraordinary circumstances (such as strikes) beyond the control of a given hospital. The burden would be on the hospital to demonstrate the effect of such extraordinary matters.

9. CEILINGS ON HOSPITAL COSTS

(a) I recognize the budgetary necessity to set same kind of ceiling on hospital cost reimbursement pending adoption of prospective rate-setting.

(b) I believe such ceilings should be set by regions instead of at the Federal level as described in 4(b) above. The present limitations on routine care costs set in Section 223 of P.L. 92–603 are patently unfair to some areas of the country because they were based on national SMSA groupings established for other governmental purposes than hospital cost control. Exhibit A illustrates the extreme differences in the cities involved in one of groupings, SMSA Group I for hospitals having 100 to 404 beds. In itself, the 100 to 404 bed grouping is entirely too broad—a 130 bed hospital is a different animal than a 300 bed hospital. Hawaii was granted a cost of living increase over the basic limits based upon Civil Service Commission salary policies, but the U.S. Department of Labor figures indicate that the higher cost of living there is caused by factors other than medical care costs, like housing, clothing, etc.

(c) If such ceilings are to be based upon percentage increases in costs from year to year, I believe an overall per diem limit as presently proposed by Federal and State agencies is not equitable for the reasons outlined in detail in 4(c) above. Probably each component of service should be considered separately, and over-limit and under-limit conditions in each component should then be netted to determine the final result.

While my remarks have not covered the full range of the subcommittee's work, I hope they may be helpful in helping you reach a reasonable conclusion to the complex problems being considered.

I would appreciate receiving a complete copy of the subcommittee's report.

Sincerely yours,

CHRIS BURNS, C.P.A.

Attachment.

EXHIBIT "A"

SMSA GROUP 1—100 TO 404 BEDS

Comparative data based upon (1) average daily hospital charge as of January 1, 1975 as published in a survey by the American Hospital Association and (2) the medical care component of cost of living for an intermediate budget urban family of four extracted from a study done by the U.S. Department of Labor in Autumn 1974 (the latest available figures at the time the comparison was done). For areas with no cost of living data indicated herein, none was available in the study.

	Average daily hospital charge	Annual cost of medical care
Average	$83.08	$759
California:		
Los Angeles/Long Beach	89.08	901
Salinas/Seaside/Monterey	81.82	----------------
San Francisco/Oakland	110.76	823
Colorado: Denver	75.17	699
Connecticut:		
Bridgeport	83.68	----------------
Bristol	73.91	----------------
Danbury	79.01	----------------
Hartford	82.70	711
Meriden	69.19	----------------
New Britain	79.09	----------------
New Haven/West Haven	108.22	----------------
Norwalk	81.19	----------------
Stamford	87.93	----------------
Waterbury	84.52	----------------
Delaware: Wilmington	88.86	----------------
Washington, D.C	95.94	770
Florida:		
Miami	77.90	----------------
West Palm Beach/Boca Raton	65.74	----------------
Hawaii: Honolulu	62.50	782
Illinois:		
Chicago	83.73	776
Decatur	52.66	----------------
Rockford	57.71	----------------
Springfield	69.17	----------------
Massachusetts:		
Boston	105.14	711
Brockton	87.69	----------------
Lawrence/Haverhill	90.98	----------------
Lowell	91.84	----------------
Michigan:		
Ann Arbor	82.08	----------------
Detroit	91.37	769
Flint	74.05	----------------
Minnesota: Minneapolis/St. Paul	69.14	691
Nevada: Las Vegas	72.37	----------------
New Jersey:		
Jersey City	84.61	----------------
New Brunswick/Perth Amboy	73.37	----------------
Newark	84.25	----------------
Trenton	79.06	----------------
New York:		
Suffolk/Nassau	114.62	----------------
New York City	128.57	816
Rochester	87.74	----------------
Ohio: Cleveland	97.32	727
Virginia: Richmond	62.65	----------------
Wisconsin: Milwaukee	72.01	697

STATEMENT OF THE CATHOLIC HOSPITAL ASSOCIATION

CONCLUSION

Rising costs in the health care industry are the joint responsibility of the public, the providers and the government. We at The Catholic Hospital Association are concerned, however, that too much emphasis has been placed on the dollar aspect of the problem. Arbitrary cutbacks hit at quality and availability. And, the first to suffer are the sick, the poor and the elderly. We urge Congress to fully analyze the problem, seeking to preserve the best aspects of our current system, its pluralism, its voluntary character, its creativity and its service commitment, while, at the same time, remedying its deficiencies.

SUMMARY OF RECOMMENDATIONS

1. The Catholic Hospital Association believes that issues of quality and delivery of care cannot be separated from those of cost and financial reimbursement and, therefore, programs at the federal level should be coordinated through a single mechanism and not function in isolation.
2. We strongly support the extension of the public comment period on proposed federal regulations from the current thirty to sixty days.

3. CHA encourages the continued use of the "Notice of Intent to File Regulations" even further in advance of the actual rule-making.

4. We continue to endorse the administration of Medicare and Medicaid on a private intermediary basis, subject to state coordination and federal standards.

5. The Catholic Hospital Association endorses the principle of prospective reimbursement adequate to meet the financial requirements of the individual health care institution.

6. We advocate, however, the trial use of several alternative systems of prospective reimbursement and that individual hospitals be allowed maximum flexibility in adopting a system which reflects their local and patient needs.

7. We encourage the adoption of incentives and shared savings in any reimbursement system.

8. CHA insists on the continuation of the voluntary health care delivery system and that protection for such systems be structured into the law.

9. We recommend that, in computing costs to be reimbursed prospectively, costs outside the management and control of the hospital be permitted to "pass through" as cost exceptions for reimbursement.

10. The Catholic Hospital Association strongly opposes the implementation of any system of prior approval or restraint on hospital contracting.

11. We also oppose arbitrary bans on the use of percentage payment contracts and urge the development of, and the adoption of a standard of reasonableness by which such contracts should be measured.

12. CHA advocates the development of system for recognizing quality of care in relation to costs, including the expansion of service.

STATEMENT

The Catholic Hospital Association is the national association of Catholic-owned and sponsored health facilities in the United States. Our nearly 900 institutional members have more than 160,000 acute care beds, making us the largest single system of voluntary hospitals in the country. For more than a century our members have served in all areas of the country—urban and rural, inner city and suburbia. Our dedication to the sick and the poor needs no reiteration. Our commitment to continue as a part of the pluralistic health system is as strong as ever. With the growing cooperation and partnership of the government we hope to be able to serve in an even greater capacity in the years to come, especially in the developing health-gap areas, such as among the aging, in the inner city and the rural setting.

One of our greatest concerns, however, is maximizing the quality of health care delivered to all components of our society within reasonable and effective cost restraints. We recognize the national concern which has been focused on the rising cost of health care. Our members have taken active and leadership roles in addressing the problem areas which are within our scope of control. We also recognize, and take this opportunity to state once again, that many, if not most, of the root causes of inflation in the health care sector are caused by conditions entirely outside of the system and outside the control of individual providers and institutions.

MEDICARE AND MEDICAID

One of the principal contributors to today's economic crisis in health care delivery has been the tremendous increase in demand for services which was precipitated originally by the introduction of Medicare and Medicaid in 1966–67. Medicare has extended health services to a whole segment of our society, but not without a cost to the system. The capability of the delivery system has been stretched to its limit. Utilization of health services exceeded all expectations. Medicaid has had more difficulty. Faulty administration, eligibility controversies and even some fraud and abuse have driven costs beyond even the most liberal estimates. We have learned many lessons from ten years under Medicare/Medicaid; it is time to apply these to the system so that the same mistakes will not be made under any system of National Health Insurance.

FEDERAL ADMINISTRATION AND REGULATION

Time and experience have shown that, for the system to operate at a maximum effectiveness, reasonable rules and regulations effectuating a concise and consistent national policy must be adopted. Rules are changed so often and with such apparent disregard for precedent that it has become virtually impossible for a provider (yet alone, the government official charged with enforcement) to know at any one time where the program stands.

The Catholic Hospital Association is concerned that there are efforts to fractionalize the administration of health care in this country and to separate the issues of delivery and quality of care from financing and the cost of care. *We believe that issues of quality of care and delivery cannot be separated from those of cost and financial reimbursement and, therefore, programs at the federal level should be coordinated through a single mechanism and not function in isolation.* The nation's health is a priority issue today and will continue to be in the future. It should be given the centralized coordination it deserves.

Health policy must be better coordinated. We cannot speak of cost effectiveness and financing as if they were separate and distinct issues from quality, distribution and availability. Under the current system, advocates of expansion of health care services (and, thereby, resulting cost increases) are speaking out from one agency, while others are promulgating arbitrary cost ceilings and restraints which tend to result in service cutbacks and to stifle the expansion before it can be started.

The hard decisions of quality care, delivered on an optimum basis, but at a fixed price, can only be made when all factors are concurrently reviewed. Isolated, departmentalized government decision-making is not compatible with quality of care, delivery and cost containment.

FEDERAL REGULATIONS—COMMENTARY PERIOD

We support proposals to increase the length of time in which the public can receive and respond to proposed federal regulations on health care. In the past, the 30-day comment period has proven to be extremely burdensome, especially when data must be gathered from health care facilities all across the country. We recognize that particular circumstances may require more expeditious handling, but, as a general rule, *we strongly support provisions which would extend the public comment period on proposed Federal regulations to 60 days. We also encourage the practice of filing "Notices of Intent to File Rules and Regulations" even further in advance of actual rulemaking.*

STATE AND PRIVATE ADMINISTRATION

We continue to endorse the administration of Medicare and Medicaid on a private intermediary, state-coordinated basis. The Federal Government has a role in establishing and monitoring uniform standards and in evaluating the performance of state plans vis-a-vis national objectives. However, State governments must be in a position to assure the availability, the access, quality and viability of needed health services. Private intermediaries have proven that, when given adequate utilization controls, they can provide the fastest and most economical claims processing service. We encourage the continued use of these private agencies in the administration of the programs.

We support the creation of standards for claims processing and the development of incentives to encourage even further reducations in administrative overhead. It is our opinion that the private administration of these programs will result in the maximum benefit/overhead cost ratio.

COST OF SERVICE REIMBURSEMENT

Perhaps one of the most maligned systems of health care reimbursement in this country has been the heretofore nearly universally applied system of retrospective "cost" reimbursement. Such payments are difficult to defend as not having a highly inflationary impact on the cost of health care delivery. To recognize this point is the first step in bringing about required change. *The Catholic Hospital Association endorses the principle of prospective reimbursement, adequate to meet the financial requirements of the individual health care institution.* What must be avoided, however, are arbitrary and inflexible caps which do nothing to curb cost increases, but simply impose the burden of such inflation on those institutions and health care recipients least able to bear up under it. Such arbitrary caps unfairly penalize institutions serving the high users of health care—the chronically ill, the disabled and the elderly—where cutbacks in the availability of services can achieve the most "cost-effective" result.

Frequently, it is the older, least efficient health facility, most in need of renovation, which is the primary source of service to the sick-poor and the elderly. It is in this facility, in the inner-city or changing neghborhood environment, which is most hindered by such arbitrary caps which provide no exception for unusual case-load mixtures and which rule out capital accumulation which would permit expansion and improvement of service. Catholic hospitals have served or large cities for years and continue an active presence in the decaying center city. In many of our older cities Catholic hospitals, to a large extent, represent the last voluntary health presence to large parts of these communities. Some of these institutions have a patient population which is 80 percent or more Medicare and Medicaid. It is on these institutions, particularly, that the burden falls—a burden which, unfortunately, can be met only by cutbacks in service or by the eventual deterioration of the institution and its ability to serve. Such a system of arbitrary caps by one governmental agency may achieve a goal of cost containment, but, at the same time, makes a goal of quality care with reasonable access more difficult, if not impossible, to achieve.

PROSPECTIVE REIMBURSEMENT

The Catholic Hospital Association suggests that there has not yet been enough experimentation with various systems of prospective reimbursement to designate any single system as a standard for the nation as a whole. Systems based on prospective rate setting offer some advantages, but they may be outweighed by prospective systems of cost reimbursement. In addition, there are many variables in the types, intensity and breakdown of service loads and occupancy patterns. Demographic and geographic variances cannot be comparably aligned under any one single system. *We, therefore, advocate that several alternative systems of prospective reimbursement be established and that individual hospitals be allowed the option of choosing a system which recognizes its particular local and patient needs.* Health facilities should be allowed to switch systems, but only after giving reasonable notice of their change in accounting practice. After a period of experimentation, the number of alternative reimbursement systems could be narrowed to a more workable number which would then become standardized for the nation.

INCENTIVE REIMBURSEMENT

The past pattern of retrospective cost reimbursement offered no incentive to curb unnecessary increases in costs. Even under prospective reimbursement, this pressure, while abated, will continue. Increases in productivity may be achieved through the use of incentives, including a sharing of cost savings between the institution and the third-party payor for services. *We encourage the adoption of incentive-based reimbursement programs wherein savings can be shared by the provider in order to encourage even greater improvement in the future.* Proposals such as those contained in S. 3205, providing for a 50 percent sharing of cost savings (up to 5 percent) are to be encouraged.

PRESERVATION OF THE VOLUNTARY SYSTEM

The Catholic Hospital Association believes that the voluntary system of health care delivery must be preserved as an integral part of any program of National Health Insurance and governmentally-financed health care delivery. *We, therefore, encourage Congress to structure such programs to specifically identify and preserve the voluntary health care facility.* Specifically, *we recommend that at least the current ratio of voluntary health care facilities be allocated to the voluntary component and that a guarantee of this share be written into the law.* Unless such an allocation is guaranteed, The Catholic Hospital Association believes that the voluntary system will be forced out of existence as we have seen similar occurrences in some European countries and, to a certain extent, in Canada.

UNCONTROLLABLE COSTS

Many of the costs incurred by a health care facility are beyond the management and control of the facility's administration. Since we are a service industry, we are subject to the same inflationary pressures as all consumers of raw, basic products. As the price of steel and other components goes up, so does the cost of many of the products which we use. Similarly, food costs and the factors of inflation upset the budget equilibrium of the hospital as much as it does the household. *We recommend that, in computing costs or rates to be reimbursed prospectively, that such uncontrollable costs be allowed to pass through as exceptions.* Specifically, we can identify the following as items which should be allowed to so pass through:

1. Technology changes which accelerate the obsolescence of capital equipment;
2. Capital costs generally as they relate to certificated and approved changes in hospital facilities, services, etc.;
3. Education and training costs of health personnel. including physician residents and interns;
4. Energy costs associated with heating or cooling the hospital;
5. Malpractice and liability insurance costs;
6. Inflation adjustments which may be factored in during any one reporting period; and
7. Taxes as they may be applied to hospital property and equipment by state and local governments.

HOSPITAL CONTRACTING

Many proposals have been discussed to limit or reduce the authority of hospitals to contract for services, supplies, equipment and personnel. Most of these take the form of requiring that some bureaucratic official—even to the secretarial level—would make a prior determination as to the reasonableness of all hospital contracts above a certain dollar level. This threshold has been set as low as $10,000. In a modern hospital almost all service contracts, quantity purchase agreements, supplies and material can reach that level.

We see a major problem in the use of "prior approval" requirements. Hospital administration is a highly specialized management field. To so dramatically limit the prerogatives and flexibility of the management team can only hinder the operation of the facility and, in the long run, reduce competition and actually increase costs by adding unnecessary layers of bureaucratic red tape.

Such additional "regulation" is duplicative and simply compounds the problem. Assuming reimbursement will be on a prospective basis, contracts entered into by hospital management will already be scrutinized within the general parameters of the prospective determinations. If a contract is excessive, unnecessary or wasteful, the prospective reimbursement system will operate to mitigate, if not completely reduce, its cost impact. Competency is rewarded under the system already outlined. If unreasonable or excessive costs are incurred, they will be caught by the prospective reimbursement system. To provide otherwise removes the very important element of local community involvement and control and reduces management to the level of mere functionaries. *The Catholic Hospital Association strongly opposes the implementation of any such prior approval restraints on hospital contracting.*

PERCENTAGE CONTRACTING

Other proposals in the Medicare/Medicaid cost area have suggested a limitation, if not an outright prohibition against the use of percentage of cost (revenues) contracting. Most frequently, these types of contracts are found in the employment of certain hospital-based physicians (radiologists, anesthesiologists, pathologists, etc.) and in the use of certain management service and shared service concepts.

Again, *The Catholic Hospital Association opposes the implementation of any such arbitrary ban as a harmful infringement on the prerogatives and flexibility of management.* We believe the emphasis should be put on the total effect, the result or the bottom line, so to speak. The question to be asked is, "Is this contract reasonable under the circumstances?" We must assure that an arm's length transaction has occurred and that competitiveness is guaranteed. This, again, can be accomplished through an effectively operated prospective reimbursement mechanism. The "reasonableness" standard is, of course, a variable, but, nevertheless, is one that is capable of determination and implementation.

QUALITY ASSURANCE

The Catholic Hospital Association believes that, in the drive to control rising health care costs, questions of quality of care and effectiveness of treatment, both preventive and remedial, must not be neglected. The nation's health cannot be measured solely in dollar terms. In measuring the success of any cost control system, dollars and services today cannot be weighed against dollars and services of yesterday. If we can deliver more or better services for the same or even slightly more expense, then we can still consider our effort successful. *We encourage the adoption of quality of care measurements,* including programs for preventive health treatment, physical development and training, recreation, maternal and infant care, as well as specialty programs for the aged and the handicapped, to expand the system of delivery and to improve our nation's health.

CONCLUSION

Rising costs in the health care industry are the joint responsibility of the public, the providers and the government. We at the Catholic Hospital Association are concerned, however, that too much emphasis has been placed on the dollar aspect of the problem. Arbitrary cutbacks hit at quality and availability. And, the first to suffer are the sick, the poor and the elderly. We urge Congress to fully analyze the problem, seeking to preserve the best aspects of our current system, its pluralism, its voluntary character, its creativity and its service commitment, while, at the same time, remedying its deficiencies. We hope our remarks have identified some of these areas. We hope to be able to work together to resolve these problems in the future.

Thank you.

COMMUNITY SERVICE SOCIETY,
New York, N.Y., July 26, 1976.

Mr. JOHN M. MARTIN, Jr.,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Longworth House Office Building, Washington, D.C.

DEAR MR. MARTIN: We appreciate the opportunity to submit a written statement on the need for revisions in the retrospective cost reimbursement system used in the Medicare program. As the nation's largest social service organization, the Society supports your decision to hold hearings and introduce legislation in this area of vital importance to the public welfare.

As part of our efforts over the years to restrain increases in health costs, the Society has undertaken an economic research project to critically analyze hospital prospective reimbursement. We believe that a properly designed system of prospective payment can be a major force behind the more efficient use of this country's limited health resources. Accordingly, our project will culminate in a report to be issued this fall which recommends a model system to be applied nationally. This study will benefit from the most expert analyses and evidence available, and we would like to share it with the members and staff of the Committee.

Also, at this time, we would like to comment on H.R. 13080/S. 3205 designed in part to reform Medicare hospital reimbursement. We wish to focus your attention on a few areas where we believe these measures should be strengthened. Once such area concerns their intention to eliminate current cost-plus reimbursement in favor of a system which would reward hospitals with comparable routine operating costs less than the average, and penalize hospitals with routine operating costs substantially above average. While we agree that such a reform should dampen inflation in hospital costs, the proposed legislation leaves enough questions unanswered that we doubt the program can be successfully implemented as is.

At the outset it should be recognized that the scope of the proposed reforms in hospital reimbursement is clearly limited. The incentive reimbursement system would exclude hospital costs related to capital, medical personnel (excluding nursing), education and training, and energy. Further, for those hospitals where operating costs are significantly above average there would be no incentive to do anything except get down to the maximum reimbursement allowed, 20 percent above the mean or target rate. There is nothing wrong with achieving limited goals such as these. However, the bill's merit must be judged on whether its incentives encourage the majority of hospitals to do better than this—namely, to spend at or below the target rate.

We question whether H.R. 13080/S. 3205 can make hospitals more efficient because the retroactive adjustments for inflation appear to be too flexible. It is unclear whether these bills would limit inflationary increases to the price rise in the mix of goods and services as determined by the Secretary of HEW, *regardless* of the actual cost increase incurred by a hospital. If so, we would support such a move because it is generally the least inflationary alternative.

Our greatest concern is that if reimbursement rates under Medicare are too loosely applied, there will be no incentive for a hospital to beat inflation. We are fearful lest these bills produce an incentive for a hospital to spend right up to the allowable rate level on a basis consistent with other hospitals in the same group. This has been the case in New York State where our so-called prospective reimbursement system has in practice resembled a system of deficit financing; each hospital can incur the maximum allowable cost knowing that the future rate will be adjusted to reflect whatever was spent. The lesson is clear: a hospital reimbursement system will fail to promote efficiency unless it is truly prospective and bases inflationary increases on cost criteria which are not set by providers.

We congratulate the Committee on its efforts to make needed improvements in Medicare reimbursement because such reforms are vital not only to the success of existing programs, but to any future national health insurance program. It is our hope that a sound prospective payment system can be implemented as soon as practically possible so as to promote greater hospital efficiency while avoiding arbitrary, controversial ceilings on expenditures.

Sincerely yours,

CHARLES B. DORF,
Chairman, Committee on Health.

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT,
Washington, D.C., September 23, 1976.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives.

DEAR MR. CHAIRMAN: Enclosed is a letter which I have received from the State of Connecticut Commission on Hospitals and Health Care regarding the situation in Rhode Island and other issues relating to prospective reimbursement.

If possible, I would like to include this letter in the Health Subcommittee's hearing record of August 3, 1976.

Sincerely,

CHARLES A. VANIK,
Chairman, Subcommittee on Oversight.

Enclosures.

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT,
Washington, D.C., July 7, 1976.

Mr. F. BERNARD FORAND,
Executive Director on Hospitals and Health Care, State of Connecticut, Hartford, Conn.

DEAR MR. FORAND: In reviewing your testimony of May 14 before the Oversight Subcommittee of the Committee on Ways and Means concerning prospective reimbursement for hospital services, I have a few questions that I thought you could clarify.

Describing the Rhode Island prospective budgeting system, you said that a concurrent utilization review system was implemented in each hospital and that this system was "modeled after Chapter VIII of the PSRO manual to facilitate a smooth transition to an eventual takeover by Rhode Island PSRO, Inc., when it became operational" (p. 15). Could you give some specifics on this subject? For example, when will the takeover occur? etc.? Moreover, could you describe the role of PSRO in dealing with costs, efficiency, and problems of overutilization in hospitals? You described these areas (p. 19) as being essential in dealing with the cost spiral problem.

In another part of your testimony, you stated that to implement a system such as the Maxicap (p. 17), states would have to "obtain exemptions from the Social Security Administration regarding the titles XVIII and XIX cost principles." Could you further explain this statement?

In answer to a question concerning the effectiveness of the Maxicap as a ceiling, you explained that the first year it was used, you reduced each hospital's budget by an average of 5 or 6 percent in order to get it down from 18 percent to the Maxicap of 13.85 percent (p. 19). How exactly did you go about reducing the budgets? What did you cut out?

Answering another question, you stated at page 20 that it was difficult to guess what the savings had been in the Connecticut and the Rhode Island plans. When will you know what the savings have been? As soon as you know, I would appreciate the data.

Furthermore, I would like your explanation of what happens when a hospital does not meet its target budget. You explained that in that case, the following year, you cut the total operating expenses of such a hospital back even further. What would, or do, you do if that hospital overshoots its target budget again? Do you continue to cut it back?

A final question concerns a suggestion I made at the end of the hearing. I asked for the development of "a model program. . . . Give us at least the things that you think would be the elements in a model program so the Health Subcommittee can move forward on the matter." As of this moment, I have received no indications or guidelines of a model program that could aid us in making progress on this question. Because the Health Subcommittee is conducting a hearing on August 3 regarding prospective reimbursement, I would appreciate a prompt response to this request.

I am returning to you, for your files, the testimony that you corrected.

I want to thank you for your continued cooperation and interest in this important area of reducing health costs.

Sincerely,

CHARLES A. VANIK,
Chairman, Subcommittee on Oversight.

STATE OF CONNECTICUT,
COMMISSION ON HOSPITALS & HEALTH CARE,
Hartford, Conn., August 30, 1976.

Congressman CHARLES A. VANIK,
Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR CONGRESSMAN VANIK: Thank you for your letter of July 7th regarding my testimony of May 14th before the Oversight Subcommittee of the Committee on Ways and Means concerning prospective reimbursement for hospital services. Unfortunately, I did not receive your letter until July 26th and, therefore, could not respond as early as you had desired. I called your staff and was informed that even if the data were submitted late, the subcommittee might still find it helpful. Therefore, I have prepared the following response to your questions:

With respect to your question on concurrent review, the State Budget Office in Rhode Island negotiated the implementation of the concurrent review system for all patients in all the voluntary hospitals in May of 1974 after the expiration of federal economic controls. At that time, the hospitals in Rhode Island were under strong pressure for wage increases from their employees—a situation that gave the state an unusual opportunity to exert leverage with the hospitals. Recognizing that Rhode Island historically had one of the longest lengths of stay in the country on a matched patient basis, the Budget Office, with strong support from Blue Cross of Rhode Island, decided to attempt to negotiate a *quid pro quo* with the hospitals. Therefore, we told the hospitals that the third parties would be willing to acquiesce in the 5.3% pay raise if the hospitals would agree to implement a concurrent utilization review system on January 1, 1975. After considerable negotiations the hospitals agreed.

During the summer of 1974, the third parties negotiated a protocol with the hospitals for the implementation of concurrent review which was modelled after Chapter VII of the PSRO Manual. It was based upon the assumption that the R.I. PSRO would eventually take over any program we developed. However, the hospitals made the mistake of not involving their medical staffs in the decision to implement concurrent review, and as the time drew near for implementation the medical staffs of several hospitals raised a considerable storm. In addition, the incipient Rhode Island PSRO took the position that the State Budget Office was infringing on PSRO jurisdiction, and requested that we allow the PSRO to implement the system—estimated to take an additional year. We refused to agree to the delay but did agree to negotiate with the PSRO to iron out our differences. By agreeing to implement our concurrent review system on a staggered basis from January through May of 1975, we were able to work out an accommodation with the Rhode Island PSRO and went ahead and implemented the new system. As you can see from the attachment, within a one-year period we were able to reduce the length of stay on a matched patient basis in every single hospital in the state except one, and in many hospitals the reduction was dramatic—more than one day per admission. We estimate on a statewide basis that the length of stay was reduced by more than one-half day.

A factor which made the implementation of the system more palatable to the PSRO was our willingness to adopt Section VII of the PSRO manual as the guide for our concurrent review system. Thus, after our system had been implemented, it was relatively easy for the PSRO (after it received conditional funding) to pick up where we left off and continue implementation of the program. This year the PSRO began to conditionally delegate authority to the Rhode Island hopsitals, and it is my understanding that the R.I. PSRO is proceeding with the support of the vast majority of the medical community in Rhode Island to implement concurrent review in the hospitals.

Since I left Rhode Island just about the time the PSRO had begun its work in earnest, I do not know how successful it has been in meeting the objectives of federal law. I was encouraged, however, by the fact that the Rhode Island PSRO was beginning to review the question of the explosive growth of ancillary services at the time I left Rhode Island. In light of the enormous impact the seemingly uncontrolled and unnecessary proliferation of ancillary services is having on the runaway inflation of hospital services, I would expect that both the Congress and the states would establish on a priority basis mechanisms to control the growth of these services.

With respect to your question about my comment that states would have to "obtain exemptions from the Social Security Administration regarding the titles XVIII and XIX cost principles," to implement the statewide Maxicap system, I offer the following explanation. Under federal law, both Medicare and Medicaid pay the lower of cost to charges with no ceiling on costs except through the rather loose controls established under Section 223 of P.L. 92–603. Thus, if the hospitals in a state increased their charges by 15% and their cost by 13% in a given year, these costs would be reimbursed to the hospitals under Titles XVIII and XIX. This federal requirement would vitiate the effect of a statewide cap of nine percent imposed by a state government since neither Medicare nor Medicaid—which often pays for up to 40–53% of all hospital patients—would be covered by the state-imposed ceiling.

To include both Medicare and Medicaid patients in its system of cost controls, it is my understanding that the state would need an exemption by the Social Security Administration under Section 222 of P.L. 92–603 to have hospitals reimbursed on a basis other than the Title XVIII principles of cost reimbursement. Once the state has received an exemption, the state would be free to set limitation not only for Blue Cross and charge base patients but also for Medicare and Medicaid, and then be in a position to implement a statewide Maxicap on hospital expenses. This is the only way in which Rhode Island was able to accomplish this goal.

You asked how we went about reducing the budget by an average of five or six percent for fiscal 1975—from 18% to below the 13.5% Maxicap. Essentially, we drastically reduced new and expanded programs proposed by hospitals, and in addition reduced the increment proposed by the hospitals for wage increases. Between the new program reductions and the reductions in proposed wage increases, we were able to reduce the budgets in the aggregate to a level under the Mexicap. With respect to the savings achieved in Connecticut and Rhode Island I can say this much at present. Based on a recent survey we did in Connecticut, it appears that the gross revenue from patients in FY '75 and FY '76 increased by approximately 15–16%. Thus, I am reasonably confident that there were little savings in Connecticut during this period. I would add, however, that the Commission on Hospitals and Health Care in Connecticut has recently adopted a proposal to limit total hospital increases in patient revenues in FY '77 to a range of 8–10% which if accomplished would reduce hospital inflation in Connecticut to a level as low as any state in the country.

Subsequent to the Commission's final decisions next month on the FY '77 budgets, I will inform you of the results of the process. Rhode Island is presently negotiating FY '77 hospital budgets under a 10.5% Maxicap. Within the next month I should be able to obtain data for you on both the level of FY '76 spending there as well as the level of budgets negotiated for FY '77 (beginning October 1, 1976).

In Rhode Island if a hospital does not meet its target budget, that budget, adjusted for volume increases, becomes the base for the increment in the subsequent year. For example, assume a hospital negotiated a $10 million budget for FY '75. A year later in its FY '76 budget submission, the hospital anticipates spending $10.7 million for FY '75, of which $300,000 represents excess volume over budget after application of a fixed/variable formula. Thus, its legitimate base for FY '76 becomes $10.3—the original budget of $10 million plus $300,000 for additional volume over budgeted levels. The hospital must absorb the difference between the $10.3 million and the $400,000 of excess spending.

If the hospital also overspends its budget the following year, its budget base would be similarly reduced as described above.

It is my experience that hospitals which experienced significant overspending the first year of the experiment took specific management action to ensure that it didn't happen again, including making changes in key personnel. I think once hospitals become convinced that the rate setters mean business, they prudently shape up their operations and become more efficient. Hospitals' perception of the strength of the rate setters and their willingness to make tough decisions is, therefore, critical to the success of a rate setting program.

I hope you find this elaboration of my previous remarks helpful to you. Please let me know if I can be of further assistance to you.

Sincerely,

F. BERNARD FORAND,
Executive Director.

Enclosure.

COMPARISON OF RHODE ISLAND HOSPITALS' LENGTH OF STAY TO U.S. AVERAGE LENGTH OF STAY FOR MATCHED PATIENTS, 2D QUARTER 1974 VERSUS 2D QUARTER 1975[1]

	Base quarter, 2d quarter 1974			Comparison quarter, 2d quarter 1975			1975 versus 1974, increase or decrease of hospital variance to U.S. average
	Hospital average stay	Average stay U.S. matched patients	Variance (days)	Hospital average stay	Average stay U.S. matched patients	Variance (days)	
Cranston-General	8.3	7.7	0.6	8.2	7.8	0.4	(0.2)
Fogarty	9.0	8.6	.4	8.2	8.5	(.3)	(.7)
Kent County	6.9	7.4	(.5)	7.0	7.5	(.5)	0
Memorial	8.1	7.6	.5	7.8	7.9	(.1)	(.6)
Miriam	10.0	9.0	1.0	9.8	9.8	0	(1.0)
Newport	8.8	8.4	.4	7.4	8.1	(.7)	(1.1)
Notre Dame	7.8	9.0	(1.2)	7.1	8.4	(1.3)	(.1)
Rhode Island	8.6	8.4	.2	8.3	8.4	(.1)	(.3)
Roger Williams	8.8	9.1	(.3)	8.6	9.7	(1.1)	(.8)
South County	6.2	6.9	(.7)	5.6	6.9	(1.3)	(.6)
St. Joseph's	10.4	9.5	.9	9.6	9.6	0	(.9)
Westerly	7.4	6.9	.5	7.1	7.0	.1	(.4)
Women and infants	4.5	4.6	(.1)	4.6	4.8	(.2)	(.1)
Woonsocket	7.3	7.9	(.5)	7.4	8.0	(.6)	(.1)

[1] Source: CPHA's PAS Length of Stay Study, summary sheets.

STATEMENT OF THE HEALTH PLANNING AND DEVELOPMENT COUNCIL FOR BROWARD COUNTY (FLA.)

Factors contributing to continuing rise in costs of hospital care.

a. Proliferation of privately owned hospitals, regardless of need

b. Duplication of equipment: Brain and full body scanners, heart catheters, equipment for critical care units. (Suggestion: Specialized hospitals through coordinated planning could relieve proliferation of major and acute care comprehensive treatment centers especially in urban areas)

c. Large write-offs from expense of treating indigent patients raise the total cost of care and is reflected in charges for Medicare reimbursements. (Suggestion: Encouragement of reimbursement from local general tax revenues and more careful screening of indigent patients at appropriate times during the treatment process)

d. Tendency of Medicare to reimburse for highly skilled care, requiring hospital stays. The types of services reimbursable seem to have been chosen rather arbitrarily.

e. Required stay in hospital before patients qualify for Medicare reimbursements for Nursing Home and Home Health Care. Cases have been cited locally where elderly people have been admitted to hospitals for the required pre-stay, solely for the purpose of gaining medicare eligibility.

f. Limited allowable number of visits for home care and for nursing home care without re-admittance into hospitals.

2. Provisions related to control of capital expenditures; relationships to the health planning process established by P.L. 93–641.

a. Medicare has come a long way in utilization review. This has contributed a great deal to holding down costs and could be strengthened with additional related health planning legislation.

b. Expensive equipment can be purchased outside of hospitals (which require certificates of need for purchases within hospitals) by private physicians, minimizing the effect of plannng efforts. Medicare could require a Federal 1122 Capital Expenditure Review by Health Systems Agencies for any reimbursement for services rendered by equipment costing over $100,000.

c. Overbuilding caused rise in hospital costs before Health Systems Agencies were designated. Need strong legislation to give HSA's the authority to close down empty beds, or convert them if possible.

3. Issues related to implementation of a prospective reimbursement system, e.g., application of the system to different types of providers.

a. Medicare could accept more forms of health care services in the hospital. Allow more paramedic personnel to provide hospital reimbursable services. Also use empty wings of existing hospitals (2,000 to 3,000 empty beds per month currently in Broward County, Florida) for convelescence, etc.

b. Encourage Medicare programs in outpatient hospital services; for instance, respiratory therapy provided as an outpatient service would prevent repeated stays in intensive care units for chronic lung disease patients.

c. Encourage reimbursement for "day-care hospital" programs. Reduce cost of overnight stays and private/semi-private rooms. With daytime care, more patients could be held in wards.

d. Medicare could enforce provision of lesser levels of care when possible to shorten hospital stays.

e. Medicare program has not taken into account social needs for nursing home care—when skilled care is not needed regularly. Access to less costly levels of care is limited to skilled needs.

Persons represented by this testimony:

Ruby Felder Powell, Director, Information and Referral for the Elderly, Ft. Lauderdale, Florida.

Sally Lakin, Outreach Counselor—Special Gerontology Project, Ft. Lauderdale, Florida.

Bruce Slipock. Area Supervisor, Service Agency for Senior Citizens, Ft. Lauderdale, Florida.

Jean Rifkin—Social Worker, Hollywood Memorial Hospital, Hollywood, Florida.

Sandra J. Fahey, Health Planner, Health Planning and Development Council for Broward County, Inc. (area HSA), Ft. Lauderdale, Florida.

[Copy of mailgram sent to Congressman Donald H. Clausen]

HILLSIDE COMMUNITY HOSPITAL OF UKIAH,
Ukiah, Calif., July 28, 1976.

We are concerned, as are other health-care providers, with the inequities of Medicare reimbursement for services rendered to patients. There seems to be total disregard for the Medicare law which requires payment of reasonable costs and prohibits subsidization of Medicare by non-Medicare payors.

Hospitals are faced with continuing increases in the costs of goods and services necessary to operate such as fuel, wages, insurance, supplies, etc., plus the additional costs of government-mandated administrative procedures such as utilization review programs, life-saving code requirements, etc.

The current reimbursement practices do not cover the cost of providing care to Medicare and Medicaid patients. It is therefore necessary for hospitals to pass on the cost of doing business to private patients and private insurance companies. It will not be long before the private sector is going to refuse to carry this additional burden which, in fact, represents double taxation. This places the hospital in the middle and will force reduction in services, both quantitatively and qualitatively, which certainly is in opposition to the stated goal in the United States of quality health care for all. Further, the reimbursement practices do not in any way reflect the mixture of inflation and increases in the quantity and quality of services being provided by hospitals on an ongoing basis.

The hospital industry has made conscientious efforts to contain costs and improve efficiency. Because it currently takes 3.8 personnel per patient to operate a hospital 24 hours a day, seven days a week, payroll costs in hospitals represent approximately 55–60 percent of the cost of doing business. Reasonable pay increases to employees therefore have an immediate impact on cost to patients. In California, hospitals are subscribing to the Commission for Administrative Services in Hospitals as a method to control labor performance to assure that personnel efficiency results in effective control of payroll dollars. Effective utilization review procedures in hospitals have resulted in reduction in length of stay, development of alternatives to inpatient care, and improvement of inpatient services. Even though we do not have control of the escalating costs of purchased goods and services, major efforts continue in containing costs in all areas by means of careful budgeting.

It is urgent that these problems are recognized and that fair and equitable reimbursement practices are restored to Medicare programs. Unless this is done health care services, particularly in rural areas, will be threatened thereby depriving many American taxpayers of quality health services which they have a right to expect available to them.

Shirley Ann Munroe, R.N.,
Administrator.

Statement of Roger Dove, Executive Director, Insurance Association of Connecticut

This statement is submitted on behalf of the Insurance Association of Connecticut (IAC), a domestic multi-line trade association, and its member companies which currently write over 25% of the commercial health insurance sold in the United States. Most of these health insurers are also members of the Health Insurance Association of America (HIAA), and we support the statement submitted to this Subcommittee by HIAA on August 3, 1976. A list of the IAC member companies is attached to this statement.

It is certainly timely and appropriate for the Subcommittee on Health of the Committee on Ways and Means to be considering the subject of health care cost control, particularly as it relates to Medicare. The IAC member companies share the Congressional and the public concern over runaway inflation in health care costs. As financers of health care, we recognize our responsibility to attempt to control costs directly and to work with government in establishing reasonable cost control mechanisms which the private sector cannot establish alone. We believe that your Subcommittee is currently studying a subject—the concept of prospective reimbursement of hospital costs—which can be established and implemented in such a way as to help alleviate the strain of rising health care costs for all users of health care.

Rather than attempting to address each of the ten topics outlined in your June 24, 1976 announcement of hearings, we would urge you to keep three basic observations in mind while considering this subject. Those observations are listed below in summary form and are followed by a more detailed discussion.

SUMMARY

1. Cost control programs should not be restricted in their application to government programs, but should, to the extent possible, apply to all users of health care.
2. Prospective reimbursement systems have proved to be effective in controlling hospital costs on a state level.
3. The federal government should establish guidelines encouraging the states to establish independent agencies to oversee a system of prospective reimbursement agencies to oversee a system of prospective reimbursement and rate and budget control for hospitals.

DISCUSSION

1. *Cost control programs should not be restricted in their application to government programs, but should, to the extent possible, apply to all users of health care.*

We realize that the primary focus of these hearings is directed at the increase in Medicare costs, and we understand the need and the desire to control the costs of such an enormous government program. Nevertheless, the larger question of total health care cost increases must be kept in perspective. We believe that, in studying a system of prospective reimbursement of hospital costs, this Subcommittee should consider the application of such a system to all hospital patients, thereby hopefully affecting a cost saving for the total health care system rather than only for the governmental sector of the healthcare system. Indeed, we believe that if a system of prospective reimbursement is applied only to governmental programs, it will not result in any real long term savings for the total health care system. Placing controls on one portion of the system is somewhat analogous to punching a pillow or pushing on a balloon. As we understand the concept of prospective reimbursement, elements of reimbursable costs would be established and hospitals would be required to operate within predetermined rates for a given period of time. Unless there is some control on the total hospital budget, any pressures brought to bear through prospective reimbursement for Medicare patients only, can and will be shifted to the nongovernmental patients of that hospital. If the cost control techniques are not established for all patients, hospitals can always resort to the escape valve of raising rates applicable to the group of patients not affected by the program. Without total budget control, the need or incentive for a hospital to be efficient and cost conscious is substantially reduced.

As will be described below, systems of prospective reimbursement of hospital costs have been and can be established to apply to non-governmental patients, and we once again urge you not to limit your deliberations to Medicare costs.

2. *Prospective reimbursement systems have proved to be effective in controlling hospital costs on a state level.*

Along with the rest of the health insurance industry, the IAC has for some time supported the establishment of prospective reimbursement of hospital costs as a means of overall health care cost control.

We strongly supported the 1973 Connecticut legislation which established the Connecticut Commission on Hospitals and Health Care. That Commission is empowered to review and approve hospital proposed operating and capital expenditure budgets, and it must approve hospital rate increases which exceed 6 percent over a 12 month period or 10 percent over a 24 month period.

Although the Connecticut system presently applies only to nongovernmental patients and hospitals, the effectiveness of the Commission in controlling costs over the first two years of operation is well documented. Prior to 1974, the increase in hospital charges in Connecticut kept up with or exceeded the national average. Connecticut hospitals increased their charges 6.1 percent in 1974 and 8.3 percent in 1975 while the national average was 11.8 percent and 13.4 percent respectively. This significant reduction in the rate of escalation in hospital charges paid by the private sector patient also translates into savings in the total cost of hospital care paid by patients including those under Medicare and Medicaid. We believe this was achieved in Connecticut without causing severe financial hardships for the hospitals and with no adverse effect on the quality of care.

We believe Connecticut can serve as a model for the establishment of a system of prospective reimbursement and rate and budget control. We think its success suggests that more states should institute a similar system of cost control.

3. The federal government should establish guidelines encouraging the states to establish independent agencies to oversee a system of prospective reimbursement and rate and budget control for hospitals.

The IAC member companies believe states can and should play a major role in health care cost control. We believe states should be encouraged to establish a system of prospective reimbursement which is based upon the best features of hospital cost control programs already established in the states of Connecticut, Maryland and Washington. These features include: (a) the establishment of a full time state commission with a full time staff; (b) an advisory group for the commission made up of provider, insurer and consumer representatives; (c) granting the commission review and approval authority over prospective rates and annual budgets; (d) establishing a uniform system of cost reporting for hospitals; (e) coordination by the commission with the state planning agency; (f) procedures for consideration of emergency rate increase requests, (g) requirements that any rate differentials must be economically justifiable and must apply equally to all patients who meet established criteria; and (h) a uniform definition of "reimbursable costs." This last element is, of course, a controversial one since there is currently a great disparity between private sector and government payments in this area, but we anticipate that the transition could be made gradually for government programs.

We believe that such a system of rate and budget control can allow hospitals to give quality care while at the same time forcing them to identify and justify high cost procedures and services and to operate efficiently.

Congress indicated its desire to have states experiment with prospective reimbursement cost control programs when it passed The National Health Planning and Resources Development Act of 1974. That law provides grants for as many as six states which have indicated an intent to regulate hospital rates, calls on HEW to establish uniform systems of cost accounting for hospitals and requires that rates be non-discriminatory as between classes of purchasers. We would hope that any legislation which your Subcommittee develops on the subject of prospective reimbursement for Medicare would include additional strong incentives for states to establish prospective reimbursement and cost control measures for all patients.

* * * * * * *

In closing, we would like to restate our support for a system of prospective reimbursement and cost control established on a state level, and applying to governmental and private-sector patients alike. We will continue to support such a program as part of our overall cost control efforts, and we would be happy to provide this Subcommittee with any additional information you may desire. We thank you for the opportunity to present our views: Ætna Life & Casualty; Connecticut Commercial Travelers Mutual Insurance Co.; Connecticut General Insurance Corp.; Connecticut Mutual Life Insurance Co.; the COVENANT group; General Reassurance Corp.; The Hartford Insurance Group; Hartford Steam Boiler Inspection and Insurance Co.; Life of Connecticut; Litchfield Mutual Fire Insurance Co.; Middlesex Mutual Assurance Co.; National Fire Insurance Co.; New London County Mutual Insurance Co.; Patrons Mutual Insurance Co.; Phoenix Mutual Life Insurance Co.; Safeguard Insurance Co.; Security-Connecticut Life Insurance Co.; The Security Corp.; and Travelers Corp.

KAISER FOUNDATION HEALTH PLAN, INC.,
Oakland, Calif., August 2, 1976.

HON. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, Longworth House Office, Washington, D.C.

DEAR CHAIRMAN ROSTENKOWSKI: This is the response of Kaiser Foundation Health Plan, Inc. to your invitation to submit written comments relating to revisions in the Medicare hospital reimbursement system. Enclosed is our statement on S. 3205 which expresses our concerns about that proposal.

In addition, we wish to comment on a number of issues raised by your announcement. First, we feel that hospitals predominantly used by members of prepaid group practice programs are likely to be treated unfairly by prospective hospital payment systems that rely upon average costs or mean costs. Prepaid group practice programs have low rates of hospital use, thus more intense cases than most hospitals. Therefore, their cost per day, or per case, may be higher than the average even though their efficiency is the same. Thus an average cost system would unfairly penalize such hospitals.

This can be partially ameliorated if the classification system used has a separate category for prepaid group practice program hospitals. Such hospitals have comparable case mixes and should be judged together.

Second, any prospective hospital payment system should have adjustments for hospital wage levels and case mix. These are two of the most important variables in hospital costs. Hospital wage levels should be used instead of general wage levels, because the latter are often not relevant in determining the wages a hospital must pay.

Case mix presents a more difficult problem than wage levels, because there has been little success in developing an adequate system for classifying and quantifying intensity of care. Nevertheless, it is important that an allowance be made for differing intensity in case mix. An appropriate means of accomplishing this objective is by allowing a hospital to request an exception for a case mix requiring greater intensity of care than the average.

Third, any ceiling on total hospital costs will tend to be arbitrary and thus result in unfair treatment for many hospitals. There is no reason for Congress to enact legislation concerning ceilings beyond that contained in Section 223 of P.L. 92–603. This section provides the Social Security Administration adequate authority to impose ceilings and provides for an exception process which is necessary in any ceiling system.

Fourth, as indicated above, a prospective hospital payment system that is based on average or mean cost may unfairly penalize hospitals associated with programs such as the Kaiser Foundation Health Plan. Moreover, such systems will pay on a fee-for-service basis which is incompatible with the operation of prepaid group practice programs. Such programs should be able to participate in Medicare and Medicaid on a prepaid basis for the services they provide, including both physician and hospital services. This is consistent with their basic method of operation. Therefore, amendments to Section 1876 of the Social Security Act and Title 19 are required as indicated in our statement on S. 3205. Such amendments and their speedy implementation are essential to insure that Medicare and Medicaid members of prepaid group programs are treated fairly.

We appreciate this opportunity to present our views to the committee. We would be pleased to assist the committee in developing appropriate amendments to implement our recommendations.

Sincerely yours,

JAMES A. LANE, *Counsel.*

Enclosure.

STATEMENT OF KAISER FOUNDATION HEALTH PLAN, INC. BEFORE THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE, UNITED STATES SENATE, July 27, 1976

SUMMARY

Mr. James A. Lane presented the following statement regarding S. 3205 on behalf of Kaiser Foundation Health Plan, Inc., the largest comprehensive group practice prepayment program in the United States.

(1) The proposed system for setting hospital rates for "routine operating costs" would result in arbitrarily established rates. Some hospitals will be unfairly rewarded by such a system while others will be unfairly penalized. It is probable that hospitals which are essential components of hospital-based prepaid group practice programs and primarily serve their members will be unfairly penalized despite the fact that studies indicate that such hospitals and programs are saving Medicare substantial sums.

(2) Prepaid programs under Medicaid should not be required to be reimbursed pursuant to the untried provisions of Section 1876 which have not been implemented even though it is nearly four years since the section was enacted.

(3) S. 3205 should include amendments to Section 1876 that provide for fixed payments which are prospectively determined and give an HMO the option of assuming all the losses or savings of the program or sharing them with Medicare.

(4) S. 3205 should include amendments to Title 19 that require states to undertake good faith efforts to enter into contracts with prepaid programs and

preclude states from imposing additional or conflicting conditions of participation upon qualified HMOs.

(5) S. 3205 should include amendments to Section 1122 that eliminate HMOs from the section and thus treat HMO providers in the same manner as other providers.

STATEMENT

Mr. Chairman and Members of the Committee, I am James A. Lane, Counsel for Kaiser Foundation Health Plan.

INTRODUCTION

Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and six independent Permanente Medical Groups comprise the Kaiser-Permanente Medical Care Program. It is an economically self-sustaining, organized health care delivery system that provides prepaid health services on a direct-service basis to over 3,000,000 members in California, Oregon, Washington, Hawaii, Ohio, and Colorado. All members join voluntarily and remain members by choice. They receive covered services from 25 hospitals, 66 outpatient facilities and more than 3,000 contracting physicians.

The Kaiser-Permanente Program is the largest group practice prepayment plan in the United States. As an organized system of health care delivery, the Program accepts responsibility for organizing and providing direct health care services. The Program has pioneered many features that Congress sought to encourage by enactment of the Health Maintenance Organization Act of 1973, such as comprehensive services, an organized system of peer review, cost control, and dual or multiple choice of health benefits plans for employees.

Our Program has over 125,000 Medicare members. The Program provides services to over 20,000 Medicaid recipients under Title 19 prepaid contracts with four states. In addition, the Permanente Medical Groups and Kaiser Foundation Hospitals provide health care on a fee-for-service basis to non-members who are Medicare beneficiaries and Medicaid recipients.

The purpose of this statement is to discuss how S. 3205 will affect hospital-based prepaid group practice programs and to suggest appropriate amendments. The bill proposes substantial changes in the Medicare and Medicaid programs. Many of them, innovative but untried, merit careful study and consideration. Some would make significant improvements in the programs and should be enacted. However, others appear to contribute little to the solution of existing problems and should be deleted.

A major thrust of the bill is cost containment. We appreciate the Congressional concern with rising health care costs which have increased significantly Medicare and Medicaid budgets. Our Program is dedicated to the effective, efficient delivery of health care services along with other prepaid group practice programs in the country. We believe Congress should amend the law so that such programs have an opportunity to provide services and receive payment for them in a manner that emphasizes their basic strengths. For too long, such programs have been forced to the disadvantage of their members to participate in Medicare and Medicaid under rules designed for fee-for-service providers.

Congress has established a national policy of encouraging the development and growth of health maintenance organizations in order to make them available to persons throughout the country. Even where HMOs exist, they may not be available to Medicare and Medicaid beneficiaries. The amendments we are recommending would improve this situation and should be adopted.

SUMMARY OF MAJOR POINTS

This presentation emphasizes the following points:

(1) The proposed system for setting hospital rates for "routine operating costs" would result in arbitrarily established rates. Some hospitals will be unfairly rewarded by such a system while others will be unfairly penalized. It is probable that hospitals which are essential components of hospital-based prepaid group practice programs and primarily serve their members will be unfairly penalized despite the fact that studies indicate that such hospitals and programs are saving Medicare substantial sums.

(2) Prepaid programs under Medicaid should not be required to be reimbursed pursuant to the untried provisions of Section 1876 which have not been implemented even though it is nearly four years since the section was enacted.

(3) S. 3205 should include amendments to Section 1876 that provide for fixed payments which are prospectively determined and give an HMO the option of assuming all the losses or savings of the program or sharing them with Medicare.

(4) S. 3205 should include amendments to Title 19 that require states to undertake good faith efforts to enter into contracts with prepaid programs and preclude states from imposing additional or conflicting conditions of participation upon qualified HMOs.

(5) S. 3205 should include amendments to Section 1122 that eliminate HMOs from the section and thus treat HMO providers in the same manner as other providers.

The hospital reimbursement proposal

S. 3205 proposes additional criteria for determining the reasonable cost of hospital services. These criteria are to be added to the existing cost determining provisions and will result in a cap on allowable costs for "routine operating costs." A hospital may receive an amount either equal to, or more or less than its actual routine operating costs, depending upon its 'adjusted per diem payment rate for routine operating costs'. However, the amount received may have no relation to what the hospital's costs should be because it will be determined in an arbitrary manner. These is no reason to believe that the routine operating costs of any hospital should be the same as the average routine operating costs of all hospitals within its classification.

In addition, the bed classifications are obviously arbitrary and to the extent that bed size is relevant in determining routine operating costs, some hospitals may receive inadequate payment merely because of the number of beds they have. However, the relationship between bed size and routine operating costs is questionable.

A more certain relationship exists between the intensity of care provided and routine operating costs. There is little doubt that the more serious cases a hospital has, the more its routine operating costs will be. This fact presents a serious problem for hospital-based prepaid group practice programs such as ours. Such programs generally have hospital utilization rate (i.e., hospital days per thousand persons) that are approximately one-half those of the traditional fee-for-service system. This is because only persons actually requiring hospital care are hospitalized and they are kept only as long as necessary. This results in more intensive cases and thus higher costs per day. Therefore, hospitals of such programs may be unfairly penalized by the proposed system unless the provision relating to intensity of care provides an adequate adjustment. Since the Social Security Administration has been attempting unsuccessfully for several years to devise an intensity factor for use in reimbursing hospitals for routine costs, we are apprehensive about the ability to develop a satisfactory approach to quantification of this factor.

On the other hand, hospitals which have less intense cases and longer length of stays will probably be rewarded by the bonus provision in the bill. It is ironic that a proposal to contain costs will probably penalize programs that have done the most to contain total hospital costs while potentially rewarding hospitals that have done little to contain such costs.

Nevertheless, most approaches to limiting hospital payments under Medicare and Medicaid will create similar problems and it is likely that any system proposed will contain arbitrary features which result in serious inequities. If this committee decides to propose a system to limit hospital payments under Medicare and Medicaid, the proposal in S. 3205 should be improved by amendments which will be discussed later.

Payments under Medicaid prepaid programs

Section 41 of S. 3205 would amend Title 19 to provide that prepaid programs under Medicaid must be paid in substantially the same manner as provided for under Section 1876 of the Social Security Act. This section should be deleted from the bill. Even though Section 1876 was enacted in October, 1972, it has not been implemented. It is untried and unproven. On the other hand, a number of states have successfully implemented Title 19 prepaid programs. None of these programs uses the Section 1876 method of payment. Requiring states to apply Section 1876 to Title 19 contracts probably will result in the elimination of most prepaid programs under Medicaid. This is an inappropriate method of controlling abuses. Qualified HMOs should be available as a choice to Medicaid recipients.

Payments under Medicare to HMOs

At the present time, prepaid group practice programs have only limited opportunities to participate in Medicare and Medicaid on a prepaid basis. For example, in our Program, the hospital services we provide under Part A are not paid for on a prepaid basis and only three of our six Regions have been able to negotiate prepaid contracts with four state Medicaid programs. We believe that Congress should take steps to enable HMOs to participate on a fair and equal basis in the Medicare and Medicaid programs in a manner consistent with their basic method of operation.

We recommend that Section 1876 be amended to provide that the per capita payments be established prospectively, so that an HMO will be able to determine the resources available to provide care. Under the present section, the amount of payment will not be known until two or three years after the care is provided!

The amount of payment should be based upon the estimated costs of services from non-HMO physicians and providers in the area adjusted for age, sex and Medicare disability status. The present section also requires an adjustment for institutional status and the difficulty in determining such an adjustment is one of the reasons the section has not been implemented. Age, sex and Medicare disability status are major determinants of utilization and adjustments for them are readily determined. The bill could provide for a study of other factors (e.g., institutionalization) which could be added as adjustments when they can be readily determined.

The section should be further amended to provide that an HMO that assumes all the risks of providing care to Medicare beneficiaries should receive all the savings from its efficiencies. Under the existing section risk basis HMOs are required to assume all the risks of providing care *plus* an uncertain payment level, but any savings must be shared equally with Medicare. This is obviously unfair.

In addition, we recommend an amendment to Section 1876 to permit HMOs to share equally in both the losses and the savings of their operation with Medicare.

HMO participation under Medicaid

We recommend that Title 19 be amended to provide that states must undertake good faith efforts to enter into prepaid contracts with HMOs and to prohibit states from imposing additional or conflicting requirements for participation upon HMOs qualified under the Health Maintenance Organization Act of 1973.

Congress has established a national policy of encouraging the development and growth of HMOs. One of the means of accomplishing this objective is the requirement of the HMO Act that most employers must offer qualified HMOs to their employees. We believe that offering qualified HMOs to recipients of Medicaid programs would be consistent with and would further that national policy.

In addition, states should be precluded from imposing additional requirements upon qualified HMOs. The HMO Act has established national standards for HMOs and those meeting the standards should not be confronted with additional and conflicting state requirements.

HMO capital expenditures

Section 1122 of the Social Security Act should be amended to remove HMOs as such from its coverage. It would continue to cover health facilities owned by or associated with HMOs, but not their capital expenditures for ambulatory facilities or non-health care construction such as parking lots or administrative buildings. Section 1122 discriminates against HMOs because it does not cover unorganized ambulatory facilities or the non-health care construction of other types of organizations.

The Senate version of the HMO Amendments removes HMOs from the certificate of need provision of P.L. 93–641. Section 1122 should be modified in the same manner so that the two provisions are consistent.

Specific provisions of S. 3205

1. P. 15, lines 5–23.—States would be required to report on utilization of services under the State Medicaid program. This requirement should be expanded to include a report on prepaid Medicaid program, with HMO participation and utilization shown separately for group practice and individual practice plans.

2. P. 22, lines 3–23.—The Secretary would be required to report to Congress on the status of state Medicaid programs. This requirement should be expanded to include a report on prepaid Medicaid programs from the information provided by the states.

3. P. 26, lines 20–25; p. 27, lines 1–2.—We are in favor of this provision which would require the Secretary to afford interested parties the opportunity to comment on major policy guidelines before they are adopted.

4. P. 29, lines 12–24.—We recommend that a fourth classification be added to this subsection: "Hospitals which provide the preponderance of their services to members of hospital-based prepaid group practice programs." Such hospitals generally differ from fee-for-service hospitals in case mixes and other characteristics. If a separate classification is not established for them, it is probable that they will be treated unfairly by the proposed system.

5. P. 30, lines 6–15.—This paragraph defines "routine operating costs" by exclusion. We recommend that this definition be retained, but that the term also be defined affirmatively. In addition to the exclusions, the paragraph should include: "costs for regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made."

6. P. 32, lines 8–25; p. 33, lines 1–9.—This provision requires an adjustment in the personnel component of routine operating costs for differences in wage levels in different areas. It also allows the use of the wage level for hospital employees if it is significantly higher than the general wage level. This provision is necessary to reduce the arbitrary nature of the proposed system. However, the use of hospital wage levels is limited to the first year. This limitation is unreasonable and should be deleted. If it is not, it would require hospitals to bring their wage levels into line with the general wage level in the area within one year or be penalized. For most hospitals, this would be impossible.

7. P. 34, lines 13–18.—This provision requires a retrospective adjustment in the 'adjusted per diem payment rate for routine operating costs' at the end of the fiscal year. We recommend that this requirement be deleted. We believe that the payment rate should be fixed in advance and both hospitals and the Medicare and Medicaid programs should live with the fixed payment level. Retrospective adjustments based upon price increases create unpredictability for hospitals. A major objective of this bill should be the establishment of prospective rates so that hospitals can plan accordingly and the programs will have more certainty in their cost estimates.

8. P. 37, lines 1–13.—This is a special provision for underutilized hospitals in underserved areas. We support such a provision as necessary to prevent unfairly penalizing rural hospitals.

9. P. 37, lines 14–25; p. 38, lines 1–3.—This provision attemps to provide for an unusual case mix in a hospital which requires greater intensity of care. This is an essential provision and we support the concept. However, it is questionable whether the provision will achieve its objective. In order to work, an accurate measure of intensity is needed. The Social Security Administration has been unable to develop such a measure for use in reimbursing hospitals for routine costs and it is doubtful if it is possible to develop a satisfactory intensity factor in the near future.

10. P. 40, lines 9–25, pp. 41–47, p. 48, lines 1–14.—This provision is designed to encourage the closure or conversion of unneeded hospitals. We support this objective, but it may not be accomplished by this provision. The transitional allowance can be paid only to hospitals which continue to provide services so that there is no assistance for total closure. It is not clear whether the transitional allowance would cover all added costs or only Medicare and Medicaid's share of them. In addition, the hospital must carry out the conversion or closure before it is eligible for the transitional allowance and even then, it may receive no assistance because of the 50-hospital limit on participation. We suggest that Congress might approach this problem directly by considering an experimental reverse Hill-Burton program. Under such a program, government funds could be used to purchase and close unnecessary hospitals. Such an approach has potential for containing hospital costs.

11. P. 79, lines 17–25; p. 80.—We have recommended the deletion of this provision which would tie payment for Medicaid prepaid programs to Section 1876 requirements. However, if it is not deleted, it should be amended to insure that existing prepaid Medicaid contracts are not jeopardized. The section should not be effective until Section 1876 is implemented and fully operational and the regulations governing this provision have been adopted. It should not apply to contracts in existence on its effective date, but only to subsequent renewals or new contracts. Moreover, the requirement for prior approval of such contracts by the Secretary (p. 80, lines 17–19) should be deleted. This requirement would serve only to further delay the implementation of prepaid contracts.

I will be pleased to respond to questions from the Committee.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., July 3, 1976.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health,
Washington, D.C.

DEAR MR. CHAIRMAN: It is my understanding that a hearing will be held on August 3 to consider the problem of reimbursement for services provided for Medicare and Medi-Cal patients.

I recently received the enclosed resolution adopted by the Board of Supervisors in Mendocino County, California, acting as the Governing Board of the Mendocino Community Hospital. I would appreciate your making this resolution a part of the official hearing record.

Thank you for your assistance in this matter.

Sincerely,

DON H. CLAUSEN,
Representative in Congress.

RESOLUTION NO. 76-218—PROTESTING THE LIMITATION OF ALLOWABLE MEDICARE COSTS

The Board of Supervisors hereby resolves as follows:

Whereas prices of goods and services in this nation are controlled by the trends of the economy not by a single industry and least of all by a single thirty-eight bed hospital; and

Whereas costs not covered by medicare and medicaid must be recovered from charges to private patients magnifying the effect of inflation in that sector; and

Whereas the intent of congress when establishing the Medicare program was that the program carry its full share of costs: Therefore be it

Resolved, That (1) no further reductions be made in the allowable cost for routine services; (2) that the present limitation be discontinued immediately; and (3) the Congress find that further limitation of allowable costs as proposed by the President are inimical to the interests of private patients who must bear the extra burden of costs not born by Medicare and Medicaid.

The foregoing resolution was introduced by Supervisor Eddie, seconded by Supervisor Avila, and carried this 1st day of June 1976 by the following vote on roll call: Ayes, supervisors Williams, Eddie, Avila, Galletti; noes, none; absent, none.

Whereupon the Chairman declared this resolution passed and adopted and so ordered.

Attest:

VIOLA N. RICHARDSON,
Clerk of said Board.

——— ———.
Deputy Clerk.

——— ———.
Chairman, Board of Supervisors, County of Mendocino.

STATEMENT OF NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, Members of the Health Subcommittee of the Ways and Means Committee, my name is Nelson H. Cruikshank. I am president of the National Council of Senior Citizens.

The National Council of Senior Citizens is a nonprofit, nonpartisan organization of more than 3,500 older people's clubs in all states, representing over three million members.

Our members were in the forefront of the long campaign for the enactment of Medicare. In fact, the late President Lyndon Baines Johnson, in a White House announcement on June 28, 1968, said: "Without the National Council of Senior Citizens, there would have been no Medicare." You can understand, therefore, that we are particularly grateful for the opportunity to present the views of the National Council of Senior Citizens with respect to the problem of rising hospital costs and possible revisions in the present retrospective cost reimbursement system used in the Medicare program.

The large, complex, and urgent problem of hospital costs, which is the subject of this hearing, should not, indeed cannot, be considered in isolation from other closely related major health care issues. Steeply rising health care costs and their financing is only one problem which has kept the nation in a state of crisis in health care. Rising costs must be seen in relationship to three other categories of problems which Dr. I. S. Falk, Professor Emeritus of Public Health at Yale University, clearly identified and described in his Michael M. Davis Lecture in 1971. We quote from that lecture:

> The major causes of crisis in medical care start with the fiscal difficulties of relatively high costs and comparatively steep annual escalations, but the causes go on to areas which present even more complex and more perplexing questions than concern the finances. A hundred problems which could be enumerated can be subsumed under four categories, and, usefully, in the following sequence—(1) National shortages in various categories of health manpower and facilities, (2) steeply rising costs and their financing, (3) inadequacies in the system for the availability and delivery of care, and (4) lack of sufficient controls for the assurance of quality of care.
>
> These causes of crisis are not discrete and separate. On the contrary, they are interlocked one with another. Therefore, if we would surmount the crisis, we must deal with all four and with their interrelations. There are some who counsel and advocate that we should deal with each category separately, pursuing each as opportunity, need, or pressures dictate—essentially continuing what we have been doing for decades. This is a counsel of caution, but not of wisdom. It will avail us little, if we merely try to produce more manpower or facilities without assuring the availability of funds and a better system for their utilization. It is unlikely we can contain the escalation of costs without a better system for the containment of unit costs of service and for the assurance of reasonable economy in volumes of utilization. It is not reasonable to expect we can have or can afford, either adequate health manpower and facilities or acceptable financing without a better system of delivery. And merely providing more purchasing power for medical care will further strain the resources for service and will surely increase the upward push of prices. Commitment to attack any one problem area does not stay a heightening crisis from the others.

Mr. Chairman, that lecture by Dr. I. S. Falk, entitled "National Policies and Programs for the Financing of Medical Care," which was delivered at the University of Chicago on May 20, 1971, is pertinent to the problem we are discussing today.

The health care crisis is still with us. It is made up of the same four categories which Dr. Falk described, but they are much more serious now.

Also unchanged is our unwillingness or inability, as a nation, to do what he advised: "deal with all four and with their interrelations." The hearing, today addresses itself to only one of Dr. Falk's four categories and, in fact, only one aspect of that problem, rising costs of hospital care.

The President's Council on Wage and Price Stability released in April 1976 a report entitled The Problem of Rising Health Care Costs, which provides exhaustive documentation of the subject of these hearings. Tables from this document have been reproduced herein.

TABLE I.—ANNUAL RATES OF PRICE INCREASE

[In percent]

	Premedicare, July 1959 to June 1966	Postmedicare, June 1966 to June 1971	Controls, August 1971 to April 1974	1975 post-controls April 1974 to December 1974	December 1974 to December 1975
CPI, all services less medical care	2.0	5.8	5.2	9.5	7.7
CPI, medical care services	3.2	7.9	4.9	12.1	10.3
Hospital service charges	NA	NA	4.6	14.6	13.0
Semiprivate room charge	6.0	14.8	5.7	16.9	14.7
Physicians' fees	2.9	6.9	4.0	12.8	11.8
Dentists' fees	2.3	5.9	4.2	9.6	7.8
Drugs and prescriptions	—.7	1.0	.7	7.8	7.4

Source: U.S. Department of Labor, Bureau of Statistics. Cited in: "The Problem of Aging Health Care Costs," Council on Wage and Price Stability, April 1976.

TABLE II.—RATES OF INCREASE IN HEALTH CARE PRICES

	Current month, June 1976 over May 1976		Prior month, May 1976 over April 1976		June 1976 over June 1975	June 1976 over June 1974	Calendar year to date, June 1976 over December 1975		Fiscal year to date, June 1976 over June 1975		Since ESP, June 1976 June 1974	
	Monthly	Annually	Monthly	Annually			Period	Annually	Period	Annually	Period	Annually
CPI, all items	0.5	6.6	0.6	7.4	5.9	9.3	2.3	4.6	4.8	4.8	18.2	8.0
CPI, all services	.6	7.7	.4	4.8	8.3	9.8	3.7	7.5	7.7	7.7	21.5	9.4
Medical care	.6	7.5	.6	6.8	9.3	12.5	5.2	10.6	8.2	8.2	26.2	11.3
Medical care services	.6	7.7	.6	7.0	9.8	12.9	5.4	11.1	8.5	8.5	27.5	11.9
Hospital service charges	.3	3.3	.3	4.2	12.2	15.4	5.9	12.2	10.4	10.4	32.9	14.0
Semiprivate room	.7	9.0	.3	3.2	13.9	17.3	6.4	13.3	10.9	10.9	38.1	16.1
Physicians' fees	.8	10.1	.6	8.0	11.6	12.3	5.6	11.5	11.0	11.0	29.1	12.5
Dentists' fees	.6	7.3	.5	5.8	6.1	11.1	3.1	6.2	5.3	5.3	20.1	8.8
Drugs and prescriptions	.4	4.9	.6	7.9	6.1	9.2	3.3	6.7	5.5	5.5	17.1	7.6

Source: "Consumer Price Index Report," Bureau of Labor Statistics.

The data indicate a sharp rise in the rate of increase in prices for health care after the introduction of Medicare and Medicaid in 1966. As observed in the above report I have cited, "medical care services prices rose at a 7.9 per cent annual rate from 1966 to 1971, compared to a 3.2 annual rate for the prior six-year period. However, even before 1966, health care prices were increasing a great deal faster than other consumer prices; this is evidence that forces were already at work to cause a more rapid rate of price increase in this section. This trend was particularly noticeable for hospital charges: semi-private room charges, for example, rose at 6.0 per cent annually from 1959 to 1966, while service prices outside the medical sector were increasing 2.0 per cent annually."

The report also notes that, "since controls ended in April 1974, health care prices have again risen more rapidly than other prices—and at faster rates than ever before, hovering in the double digit range throughout the period. In addition, substantial price increases are now spread throughout the sector: while previously, most concern was focused on hospital charges, physicians' fees and drug prices have also been escalating at unprecedented rates since the end of controls."

Table II provides the latest data available on rates of price increases in the medical components of the CPI, through June of 1976, inclusive. Although the rate of increase in prices appears to have moderated slightly between June of 1975 and June of 1976, hospital charges and physicians' fees are still the fastest rising components of health care, and are roughly double the overall rate of increase of the CPI.

Among several factors contributing to the continuing rise in the costs of hospital care are:

GENERAL INFLATION

The most obvious factor contributing to the rising cost of hospital care is general inflation in the economy as a whole, although this is by no means the most important factor. In fact, the inflation rate in the health care sector exceeds the general rate of inflation. It appears possible that the health care sector of the economy is helping to force up general price levels, rather than the other way around. Therefore, even if inflation were to be brought down to moderate levels for the economy as a whole, relative prices in the health care sector would remain at unacceptable levels.

TOO MANY HOSPITAL BEDS

There are numerous factors which contribute to rising hospital care costs. Among them is the number and allocation of hospital beds. Although there are a few communities in the USA which need additional hospital beds (or at least need to have obsolete ones replaced), most communities have too many hospital beds, yet still want to build more. This is a wasteful use of limited resources. It is wasteful not just because communities spend huge sums building facilities that are not really needed, but once they exist, incentives are provided to assure that the excess beds are used, even if less costly alternatives exist. Rate readjustment schemes which accept the given framework of medical care delivery will not correct the problem.

TOO MANY EXPENSIVE FACILITIES AND SERVICES

Just as there is a strong tendency to build too many new hospitals or to add unneeded beds to existing ones, there is a tendency for hospitals to have available all the services their medical staffs might want to provide for their patients, with little consideration of how often such services will actually be required, or that the particular service or facility is already available in adequate quantity in one or more nearby institutions. Again, just as is the case with unnecessary beds, the existence of unnecessary hospital services and faciilties triggers forces that compel their use. Denying reimbursement for costs based on excess facilities would be a step in the right direction.

TOO FEW LEVELS OF CARE AND INFLEXIBLE USE OF LEVELS OF CARE THAT DO EXIST

A wide variety of different kinds of care are needed in providing personal health care services for the residents in any community. They range from primary preventive services, such as immunization against infectious diseases, to care of terminally ill patients for whom medical science has done all that it can. There are several different degrees of intensity of care required to serve different patients at different times. There is, for example, primary care—usually available in a private physician's office, or clinic, or hospital emergency room. Other examples are general hospital care, which can be divided into routine care, acute care, intensive care, cardiac care, convalescent care, extended care, self care, home care, etc. More might be added. But this list is long enough to make the point that most people, sometime during their lives, are likely to need several of these levels of care.

However, all of them do not have to be available in one local general hospital. Yet, there is a strong tendency for most hospitals to try to provde many of them, or more frequently, to keep inpatients in the level of care they are able to provide, even though it may not be the level of care most appropriate to the patient's needs at any given time, and even though other levels of care would be less costly and better suited to the needs of the hospital. Reimbursement schemes which are based on the costs of required facilities over a medical market area would be helpful, but it is important to note that "medical market area" is not synonymous with "state," which is a political jurisdiction and not an economic jurisdiction.

ABSURDITIES AND RIGIDITIES IN THE USE OF HEALTH CARE PERSONNEL

In addition to abuse of physical resources, another abuse is our wasteful and inefficient use of health care personnel. We overuse highly paid, trained professional persons to perform duties which could be done as well, and sometimes better, by semi-professional, para-professional, and volunteer personnel, and sometimes even by patients, themselves. We waste personnel (and therefore money) by locking in people to narrowly defined health careers, instead of encouraging easy lateral transfers from one specialty to another. This over-specialization results in our having too few generalists, trained to perform a wide spectrum of duties in settings where they are permitted to do so. We also make it difficult for relatively low paid, less well trained personnel to have upward career mobility. All these rigidities are wasteful, not only of money, but of human talent and deprive consumers of a reasonable spectrum of services at a reasonable price. Rate adjustment schemes which treat physicians' fees lightly and yet constrain the wages and salaries of other medical personnel will not correct the problem.

INADEQUATE ATTENTION TO PATIENT EDUCATION

Too few hospitals have patient health education programs, yet patient education should be a part of any therapeutic regime. This will enhance patient responsibility for self care and encourage better cooperation with professional health care personnel. Inadequate attention to patient education is wasteful of personnel and resources and contributes to rising hospital costs. Lack of attention to consumer education forces the consumer to accept services at unduly high price levels or to forego needed services altogether.

INADEQUATE ATTENTION TO PREVENTION

Our health care system gives too low a priority to preventive health services (primary, secondary, and tertiary prevention). This leads to unnecessary illness and to excessive need for long term and custodial care—all at a higher price than prevention.

MALPRACTICE INSURANCE

A cumbersome system of malpractice insurance is prodigiously costly to hospitals and physicians.

COMPLICATED AND VARIED REIMBURSEMENT SYSTEMS

Hospitals must deal not only with Medicare and Medicaid, but Blue Cross-Blue Shield, and a wide variety of other third party payers. This adds greatly to administrative costs which are passed on and become a part of the price patients must pay. This argues for minimizing the number of third party payers, and not simply rate readjustment.

BADLY DESIGNED PUBLIC AND PRIVATE FINANCING

Last, but certainly among the most important, is the incentive structure provided by both public and private health insurance models. Any scheme which provides reimbursement for the most costly of medical services—hospital care—while neglecting or providing only partially and only on a voluntary basis coverage for alternative forms of care, must of necessity provide an incentive to both doctors and patients to abuse the use of the covered service. We can only constrain costs without affecting the quality and quantity of health care by expanding the supply of alternatives to hospital care and providing access to all forms of health care for all people by comprehensive financing without the barriers of deductibles or coinsurance.

Medicare was designed, out of expediency, on the private insurance model. We knew at the time it was less than perfect, and we see the results of this imperfection today. Patchwork treatment of the marginal symptoms will not correct the difficulties; only changing the model in its entirety will resolve the difficulties that confront us.

Only a national health insurance plan which offers access to all Americans to all levels of the health care delivery system, and which budgets the supply and allocation of medical resources across all areas of the country and provides incentives for increases in supply tailored to patient needs can offer quality care while constraining costs. The only proposal which fits this description is the Kennedy-Corman Bill, (S. 3, H.R. 21) National Health Security.

Although we hold to our conclusion that a band-aid approach has little chance of success, we will present our views on the specifics of proposals before this Committee.

Regulation of hospital rates by States

We see nothing inherent in the way the fifty states of the nation are divided geographically that makes them appropriate at health and hospital planning regions. If one sets aside the obvious fact of their reality as entities political, what remains that makes state boundaries useful in establishing rational areas within which to plan and legislate and regulate hospital reimbursement rates? The experience of the Department of HEW in establishing Health Service Areas under the Health Planning and Resources Development Act of 1974 (P.L. 93–641) is persuasive evidence that state boundaries must often be crossed in order to establish appropriate areas for effective planning and development of health services.

Alternative approaches to setting prospective rates

(a) *Retroactive adjustments.*—At least until a solid base of experience is acquired, the opportunity for retroactive adjustments in rates will be needed. There will need to be opportunity for reimbursement rates to be adjusted upward, if original estimates prove to be too low to make it possible for the institution to provide necessary quality care. Also there should be opportunity for the federal government, or any third party payer, to adjust rates downward, if experience proves that the original estimated rates were over generous.

(b) *Unit of payment.*—In determining the unit of payment to be used in setting reimbursement rates, we urge a variety of options including the most customary one of per diem rates with careful stipulation of the detailed and specific items of cost which are allowed in arriving at a per diem cost.

We think that incidence of illness might prove to be a workable unit of cost. With modern methods of cost accounting, it should not be difficult to determine, in advance, how much it will cost on the average a hospital to treat a case of infectious hepatitis, for example, or perform any number of simple or complicated surgical procedures, or treat acute episodes of mental illness. This approach offers the opportunity of built-in incentives to make the hospital stay no longer than medically necessary, to minimize the duration of stays in intensive care units, and maximize the use of extended care, self care and home care.

(c) *Uniform accounting, reporting, and cost allocation.*—The advantages of uniformity in administrative procedures for collecting accounting information are obvious. There must be opportunity for flexibility and use of skilled and experienced judgment in using the information, however. On a community-wide basis, uniform automated data processing procedures offer intriguing possibilities for having computers in a group of hospitals "talk to each other," and to third party payers. We urge, however, that such automated systems be instituted gradually, and only after non-automated procedures have been proved successful.

(d) *Financial incentives to providers for achieving costs savings and the disposition of incentive payments.*—As has been suggested many times already in our statement, rates should be set so as to provide incentives for health care providers to save costs by admitting patients only when hospital care is necessary, keep the hospital stay as short as possible, and within each hospital patient stay keep use of expensive procedures to a minimum consistent with high quality care. Most of the incentives in hospital payment structures today tend to encourage overbedding, overinvesting, and overutilizing. Reversing that trend would be an important achievement in bringing down, or at least containing hospital costs.

As to disposition of incentive payments, we think they should be larger if they are used to improve the quality and accessibility of health services in the community. Their use for capital costs should be prohibited. Their use for innovative programs in areas such as patient education, home care, and self care should be encouraged.

Their use by proprietary institutions to simply increase equity income should be prohibited.

Feasibility and desirability of providing to hospitals a choice among more than one reimbursement methodology; etc.

As a practical matter, it will probably be necessary to provide hopitals a choice among more than one method of reimbursement because of widely varying accounting and other administrative procedures. There should, however, be built-in inducements to encourage acceptance of innovative reimbursement procedures, have built-in incentives for cost savings and maintenance of quality control. If state rate-setting programs will help achieve these objectives, they should be utilized.

Special provisions relating to control of capital expenditures; relationship to the health planning process established by Public Law 93–641

Control of capital expenditures can best be achieved in any new legislation on hospital reimbursement procedures by reliance on the provisions of the Health Planning and Resources Development Act of 1974. Title XVI of that law revised the Hill Burton program and authorized funds for modernization of medical facilities, construction of new outpatient facilities, construction of new inpatient facilities in areas which have experienced recent rapid population growth, and conversion of existing medical facilities for providing new health services. The law sets priorities among projects within a state and sets up planning bodies through a network of Health System Agencies, and provides for designation of a State Health Planning and Development Agency in each state.

The Health Planning and Resources Development Act has only recently begun to be implemented. We think it is sound legislation, but more time is needed before the country can fully test it. It would be a mistake now to tamper with its provisions for controlling capital expenditures through new legislation on rate reimbursement. Rather, any new laws should be carefully coordinated with the Health Planning and Resources Development Act, and designed to enhance rather than interrupt or interfere with its implementation.

Legislation to reform medicare hospital reimbursement, such as S. 3205 (Talmadge) and H.R. 13080 (Duncan of Tennessee)

Senator Talmadge's bill (S. 3205), entitled Medicare-Medicaid Administrative and Reimbursement Reform Act and its companion bill in the House (H.R. 13080) have the major virtue of directing attention to the serious problems of Medicare and Medicaid, especially as they involve hospital costs. Senator Talmadge was correct when he said, in introducing his bill, "We just cannot go on this way. The increasing cost of these programs consistently outstrips the rate of rise in federal revenues." The Talmadge-Duncan bill sounds a much needed alarm about the alarming inflation of health costs.

An examination of its specific provisions leads us to believe, however, that, although many of them are timely and constructive with regard to needed changes in Medicare and Medicaid administration, including installation of a prospective hospital reimbursement system, the bill falls far short of the comprehensive approach that is now required. We agree with most of its provisions in a narrow context. But, if that bill were to become law, we would repeat the cycle of false hope at the time of its passage; delay, through enormously complicated regulations; and finally frustration and disappointment because that bill cannot achieve control of rising health care prices. Not only that, but there is the potential of an administratively complex regulatory approach actually adding to escalating health care costs.

Considerations for and against, prior to the full implementation of a prospective reimbursement system, a ceiling on total hospital cost

We can thing of no arguments for imposing an arbitrary ceiling on Medicare hospital costs. It would not achieve containment of hospital costs, because hospitals can easily turn to sources of payment other than Medicare to recover costs denied by any ceiling that might be imposed by Medicare law or regulation. Again, it is a piece-meal, or band-aid approach that might result in passing on non-covered costs to consumers or in denying them the needed services.

Summary and recommendations

The evidence is overwhelming that the solution to the persistent and worsening problem of rising hospital costs requires a comprehensive approach to needed and long overdue changes in our total national system for the delivery of health care. Our recommendations, therefore, are:

1. That the Health Subcommittee of the House Ways and Means Committee, report favorably the National Health Security bill (H.R. 21) to the full Ways and Means Committee with recommendations for early favorable action by the full Committee to get the measure to the floor of the House at the earliest possible date.
2. That as an interim temporary measure to control the escalation of health care costs that legislation be enacted to establish effective price controls in the health care industry. We are not commenting at this time on physicians' fees, since we will be presenting our views on that subject to you at your hearing on August 25.
3. That as an immediate emergency measure, a price freeze be established on all hospital charges, including not only those for Medicare and Medicaid patients, but for all patients regardless of the sources available to them to pay for hospital care.

Mr. Chairman and members of the Subcommittee, thank you for the opportunity to present our position on the crucial national issue of rising hospital costs and intimately relative problems of our total health care system.

STATEMENT OF THE NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS OF THE AMERICAN PUBLIC WELFARE ASSOCIATION, R. ARCHIE ELLIS, CHAIRMAN NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS AND WILLIAM STEWART, M.D., CHAIRMAN, COMMITTEE ON HEALTH CARE

The National Council of State Public Welfare Administrators (of the American Public Welfare Association) is largely composed of state welfare directors. Most have direct responsibility for the management and operation of Medicaid. Since state Medicaid programs are presently required to utilize the Medicare formula for hospital reimbursement (unless they can demonstrate to the HEW Secretary that the state has a superior system—Section 232, P.L. 92–603) and hospital payments comprise one third of all Medicaid expenditures, the Medicare hospital reimbursement system is of great importance to states. Increasingly, states have been concerned with the high costs of Medicaid in general and with the cost of institutional care, such as hospital services in particular. Therefore, the state welfare administrators welcome the opportunity to share their viewpoints on this important subject with the Subcommittee. This statement was developed by the National Council's Committee on Health.

THE LINK TO MEDICARE

States have long protested the legislative tie between Medicaid and Medicare—programs with similarities, but also with major differencs. This is a particularly acute problem in the area of hospital reimbursement. Many states have adopted policis designed to curb the growth in hospital costs and they have had difficulty in obtaining HEW approval to utilize these systems for Medicaid reimbursement. States have long criticized the Medicare cost reimbursement techniques as being a direct contributer to the rising cost of hospital care, but because of regulations they have had few alternatives. While the Council does not endorse any specific alternative to Medicare, we do recommend that states be allowed to utilize their own system of hospital reimbursement in lieu of Medicare's.

S. 3205/H.R. 13080

The Council has also had the opportunity to review proposed legislation to reform Medicare hospital reimbursement as offered in S. 3205 and H.R. 13080, the Medicare and Medicaid Administrative and Management Reform Act of 1976. This bill would adopt a modified incentive reimbursement program for Medicare. A review of the proposed Talmadge provisions indicates that the intended scope is limited. The three year phase-in period, the focus on only a relatively small number of hospital costs and the generous provisions for extenuating circumstances all point to a somewhat incremental approach to the control of hospital costs. The assumption underlying the proposal is that any more comprehensive or restrictive strategy is politically infeasible at this time and thus stands little chance of being adopted.

The bill does address one major problem: the adoption of a uniform accounting system for hospitals. Clearly as the data base by which hospitals are compared and reimbursed improves, the ability to monitor and control costs is enhanced. In its present form, however, S. 3205 falls heir to many of the problems of incentive reimbursement systems; the reliance on existing costs as a base measure (assumes all hospitals operating efficiently at present), the ability of a relatively small incentive payment to encourage cost savings and efficiency and the assumption that all hospitals can be compared through a classification system. Hospitals within the 20 per cent of payments margin would have no incentive to improve. The proposal goes several steps further by allowing retroactive adjustments for inflation, a relatively large (20 per cent) margin for allowable reimbursement rates (presumably without question) and by permitting consideration of numerous exceptions (such as case mix) to the basic formula on a hospital by hospital basis.

In short, the proposal would affect only those institutions whose relevant costs exceed the target rate in excess of 20 percent and who are not able to satisfactorily demonstrate the reason why those excessive costs occur. There are few hospitals who are likely to fall into this category, particularly given their recognized ability to shift costs into those sectors not covered by the reimbursement formula. In this case a number of key cost areas are excluded from the prospective system (e.g. education) and could easily serve as the repository for unapproved costs. In addition, and this is a far more serious problem, even if Medicaid and Medicare hospital costs were constrained there are no safeguards to disallow the reallocation of these costs to other third parties (the so-called "balloon effect"). Therefore, the bill may create a substantial differential between rates under third party payors, such as Blue Cross, and those under Titles XVIII and XIX. Thus, the discrimination on the basis of acceptance payment and patients—a phenomenon already experienced by Medicaid—may spread to Medicare—discrediting it as well. Thus, it appears that the Talmadge proposal, while establishing a necesary data base, would do very little to constrain the growth in costs without the use of independent criteria to evaluate costs, and without substantial safeguards on other contributers to high hospital costs.

RECOMMENDATIONS

Given the present continuous rise in hospital costs, some effort is necessary to reform Medicare reimbursement.

That, again, states demonstrating a successful program in hospital reimbursement be allowed to utilize their system—for both Medicaid and Medicare—in lieu of the rule specified in S. 3205 or any other proposal.

That retroactive adjustments not be allowed in any program adopted. States must budget expenditures for Medicaid. Required retroactive payments have the potential to elicit cutbacks in other Medicaid services, a phenomenon already experienced in many states.

That definitions be extremely clear and straightforward.

That allowable cost increases be tied not to industry figures, but to appropriate price indices.

That there be more than one primary affiliate for medical schools allowed since many states are experimenting with community based schools without walls (areas health education centers).

That, while we approve of proposals to reimburse for closure or conversion of facilities, that such efforts involve the input of local and state health planning authorities.

CONCLUSION

The National Council of State Public Welfare Administrators thanks the Subcommittee for the opportunity to present these viewpoints. We support efforts on the part of the Subcommittee to take action on this important area of health expenditures. The Council stands ready to provide additional information and assistance to the Subcommittee.

STATEMENT OF JOHN R. GRIFFITH, DIRECTOR, PROGRAM AND BUREAU OF HOSPITAL ADMINISTRATION, UNIVERSITY OF MICHIGAN SCHOOL OF PUBLIC HEALTH

I am John R. Griffith, Professor of Hospital Administration and Director of the Program and Bureau of Hospital Administration at The University of Michigan School of Public Health. I am a professional hospital administrator by training and experience. My major professional interest over the past seven years has been the design of systems to control hospital costs, including systems and procedures for facilities planning, internal management, and reimbursement. The Bureau of Hospital Administration has a contract under Section 222 of Public Law 92–603 and a research grant on hospital costs from the National Center for Health Services Research (HS 00228).

The Subcommittee's press release (Health PR #25) called for comment on the factors contributing to the continuing rise in the cost of hospital care. This is a very complex issue with responses possible at many different levels of analysis. It is a question which I have been researching for the past seven years. I have, in addition, devoted considerable time to practical efforts to stem the cost increases in Michigan. Drawing on this experience, I believe the three most basic factors which have accelerated the costs of hospital care above those of other services are as follows:

1. Over reliance on hospitalization as opposed to less expensive alternatives to care. There is a strong tendency for a large number of Americans to seek more hospital care than they need and to place more faith in hospitalization than it may deserve. This over reliance on hospitalization leads to the construction of too many hospital beds and the beds encourage further unnecessary use. There are major differences among the states in this regard. Hospital use ranges from less than the 1,000 patient days per 1,000 population in several western states to nearly 1700 days per 1,000 population in Rhode Island and West Virginia. Similar variations occur within Michigan alone. A range from 900 to 1700 patient days can be found just within the seven counties of the Detroit metropolitan area. Similar differences can be found between the other major urban areas of Michigan.[1] A confusing variety of factors characterize high and low use communities, but consistently the low use communities say that they deliberately avoided unnecessary use and construction of hospital facilities.

2. A health care system which has economically encouraged and subsidized expansion of hospitals for many years. The major factors in this subsidization process are the widespread availability of prepayment; the excessive use of cost based reimbursement and the creation of "cost pass throughs"; the Hill-Burton Program for hospital construction, and the research and development programs of the National Institutes of Health. Many of these elements have been of great social value, and I believe all of them were conceived by well intentioned people. There was, however, too little attention to the interaction effects and in the case of cost based reimbursement, a lack of understanding of the implications.

3. A lack of clarity on the part of hospital trustees as to basic goals. We find in our work that trustees tend to ignore the cost implications of expansion decisions, to be misled on trivial and false economies, and sometimes to focus on financial stability to the exclusion of cost control. I believe these problems are not unique to trustees. The American people remain very ambiguous with regard to the reduction of hospital costs. They continue to want almost instantaneous access to even the most expensive forms of hospital care, and immediate distribution of new technical advances in medicine. Also, I frequently hear both union and management trustees making statements like, "We have to cut costs

---

[1] Griffith, J. R. and R. A. Chernow, "Cost Effective Acute Care Facilities Planning in Michigan," scheduled for publication in *Inquiry*, June 1977.

but we cannot reduce wages or employment." The technology to make substantial reductions in either the absolute expenditures in hospital care or the rate of increase in hospital care costs is at hand. It can be applied as strenuously as the American people want. But, it is not painless; it involves hard decisions and difficult trade-offs. A stronger consensus on cost containment as a goal is essential to gain widespread application. It must be present among trustees and the publics they represent.

My colleagues and I have developed a technology for the control of hospital costs and have demonstrated its effectiveness with the help of the National Center for Health Services Research, the W. K. Kellogg Foundation, Michigan Blue Cross, the Greater Detroit Area Hospital Council, and about a dozen cooperating Michigan hospitals. Our findings are being published by the Health Administration Press and will be available this month.[2]

In addition to this effort, many people have worked hard in Michigan to control hospital costs and I believe we are developing an effective effort to get the job done. Actions taken by Blue Cross and Blue Shield of Michigan will reduce hospital payments by $60 million for 1976. There may be additional savings for Medicare and Medicaid. We will continue to control hospital costs in the future, but our efforts will require several years to reach complete fruition. We will need more assistance from Medicare and Medicaid in future years, since these agencies are not involved at all in current actions.

The Michigan experience, and the reports of work done elsewhere under Section 222 of the Social Security Amendments of 1972, lead me to make the following suggestions:

(1) Retrospective cost based reimbursement is no longer an effective or desirable way to pay hospitals in any situation where it dominates or has even a large fraction of the total hospital income. The Congress, therefore, should stimulate a shift to prospective reimbursement for all Medicare and Medicaid funding.

(2) The best methods for prospective reimbursement have not yet been developed and there are probably a wide variety of programs suitable to different states or parts of states. The Congress, therefore, should not mandate a single form of prospective reimbursement. It should continue experimentation and encourage flexibility and variety in the application of prospective reimbursement systems. It should also encourage collaboration between governmental and voluntary agencies such as Blue Cross. The opportunity to increase impact by integrating several third party sources together should not be overlooked. In this regard, wording like that found in Section 102 of the bill introduced by Congressman Mills entitled the "Health Care Management Act of 1974" would permit Michigan and other states to continue to analyze and solve their own problems with their own resources. I regret that I cannot find similar wording in S. 3205, submitted by Senator Talmadge this year.

(3) The Congress should establish or have the Secretary of Health, Education, and Welfare establish guidelines as to acceptable increases in costs of hospital care. These could apply to both Medicare and Medicaid but they would also be useful as advice to private funding agencies. These guides should be established for states or regions in terms of either cost per person or total annual cost. In no case should they be established in terms of per diem cost. Per diem cost guidelines provide incentive for increased unnecessary utilization of hospitals and fail to attack the most serious and rewarding area of inefficiency, that of inappropriate use.

(4) The Congress should continue to fund Section 222 activities and should continue to stimulate research and evaluation of the various approaches to prospective reimbursement which have and will develop among the states. To lose the data base that we have gained so far would be to waste most of the benefit of the investment we have made in Section 222 and would, in my opinion, be a serious loss. We will use in Michigan not only the local data funded through this section, but also the studies in other states.

(5) The Congress should encourage greater cooperation by the Bureau of Health Insurance (BHI) in well-conceived state and voluntary programs. It is obviously difficult for the BHI to comply with this, yet it seems to me that their compliance is necessary and even vital to a sound and well-conceived national program.

---

[2] Griffith, J. R., W. M. Hancock, and F. C. Munson, eds., *Cost Control in Hospitals*, Health Administration Press, Ann Arbor, Michigan, August 1976.

As addenda to these remarks, I am submitting a review of major contributions from Section 222 research and some documentation of the cost control problem in Michigan. I have also included text of Section 102, H.R. 13461, 93d Congress.

ADDENDUM TO THE TESTIMONY OF JOHN R. GRIFFITH

I CONTRIBUTIONS OF RESEARCH AND EVALUATION ON HOSPITAL REIMBURSEMENT

I believe Section 222 demonstrations have shown quite clearly that reductions in hospital cost are possible without impairing the quality of medical care and that prospective reimbursement mechanisms can help achieve such reductions. The demonstrations have also revealed a surprising diversity of results among various approaches to the problem. It is still not possible to say with certainty what specific approach will have the desired result for all the vastly different situations which occur in the United States. To put that another way, the Section 222 demonstrations show that it is possible to have prospective reimbursement and not attain the goal of controlling hospital costs. We have learned that it is a difficult and time-consuming task to design and install effective cost control systems.

At the same time, Section 222 demonstrations have helped develop a national consensus that unrestricted retrospective reimbursement leads to very rapid expansion of costs. The evidence is that the larger the fraction of hospital care financed under retrospective cost, the more rapid the expansion will be.

It appears that hospital managements are clearly motivated by the reimbursement mechanism. They will follow any expansionary incentive which might exist, whether it be retrospective or poorly designed prospective reimbursement concept. Studies conducted in Michigan and elsewhere under Section 222 indicate that many hospital administrators will effectively achieve the goals of their institution under a given reimbursement system even though these goals are in conflict with the interests of other groups.

For example, there was a marked tendency among New York City hospital administrators to increase length of stay under the severe per diem cost limitations imposed by New York Blue Cross. The result was to short circuit the Blue Cross goal of cost containment. The reimbursement limits were met, but both Blue Cross and Medicare costs continued to rise. Admission rates, lengths of stay, and other benefit and utilization issues can be manipulated by doctors and hospitals. There are even computer programs available to show them how to maximize their income under various reimbursement schemes. The Congress itself has noted that hospitals and doctors make access to medical services difficult for groups whose costs exceed their reimbursement coverage. Much of this information has been obtained and validated through the Section 222 demonstrations. They have provided evidence for both the difficulty of the problem we face and the importance of continuing investigation.

We now have growing bodies of data which permit specific comparisons of communities, states, types of providers, and approaches to reimbursement. These have become available at substantial cost through the Section 222 demonstrations. We have not yet obtained the full benefit of the data, but it has clearly proven to be a valuable resource. We need continued federal funding to keep these data current and also to continue to study the reimbursement problem. Sound, permanent systems of prospective reimbursement will not suddenly appear in their fully developed form. It will be necessary to approach them gradually over several years by continuing study of the financial impact, quality impact, and equity to hospitals and beneficiaries. Annual modification will be desirable as our knowledge and understanding increase.

II PROBLEM AND ISSUES IN REIMBURSEMENT SYSTEM DESIGN RAISED BY THE MICHIGAN EXPERIENCE

I will limit my remarks to the state of Michigan, but our experience is typical enough that I believe it has many implications for other states and for the Congress.

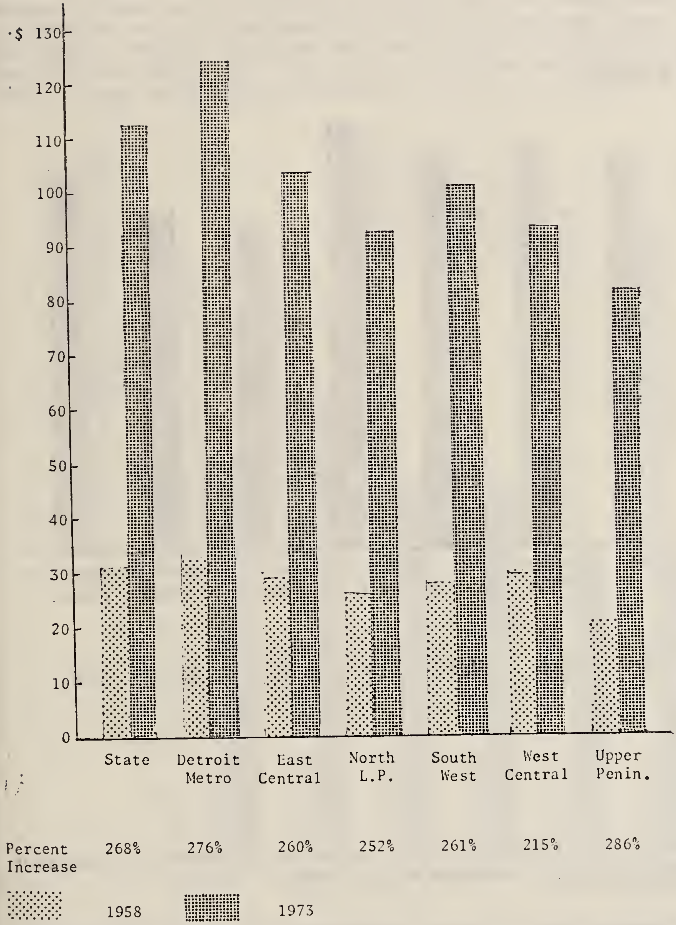
The people of Michigan and their agencies—state government, Blue Cross, hospitals—have been concerned about the cost of hospital care for many years and have been active in trying to control it. The intensity of their activity has significantly increased during the past few months. In 1971 they began to deal with the issue of reimbursement. An experimental prospective reimbursement program was undertaken by Blue Cross and hospitals in 1973. In 1975, both the state legislature and the major purchasers of Blue Cross insurance indicated that they were ready to act decisively on the issue. The state imposed a 7% increase limit on Medicaid per diem reimbursement. However, this was withdrawn in the face of court tests on the grounds that it failed to meet federal requirements for "reasonable costs." Blue Cross, with the vocal support of General Motors and the United Auto Workers, imposed a 10% increase limit or cost cap on the total inpatient costs of hospitals with allowances for malpractice costs, volume changes, and physician involvement in utilization review activities. Prior to last fall, most hospitals in western Michigan had from 20% to 50% of their revenues generated under retrospective cost based reimbursement while eastern Michigan, where Blue Coss coverage is more widespread, 60% to 90% of revenues were accounted for under this method.

As background to our Section 222 experiment, my staff and I have compiled data on hospital costs in Michigan by region over the fifteen year period 1958 to 1973. These data indicate rather striking differences in performance between various parts of the state of Michigan. The state average for per diem costs has increased approximately 270% over the fifteen year period (see Figure 1). However, Detroit costs have increased nearly 280%, while the average cost increase in the northern and western portions of the state has been only 250%, the discrepancies are not great, but they have resulted in much wider cost variations around the state average than was true in 1958. It is particularly interesting to compare the Detroit metropolitan region with the west central region. The west central region contains the city of Grand Rapids, which is well-equipped to handle a wide variety of medical services. Occasionally, but very rarely, it is necessary to refer a patient from Grand Rapids to the Detroit area for care. West central per diem costs however, have increased only 215%. Costs in 1973 were $94 per patient day as opposed to $124 in Detroit. Not all, but a large portion of this difference can be explained by the wage rates which differ between the two communities by about 20%.

FIGURE 1

PER DIEM COSTS IN MICHIGAN

BY REGION. 1958 and 1973

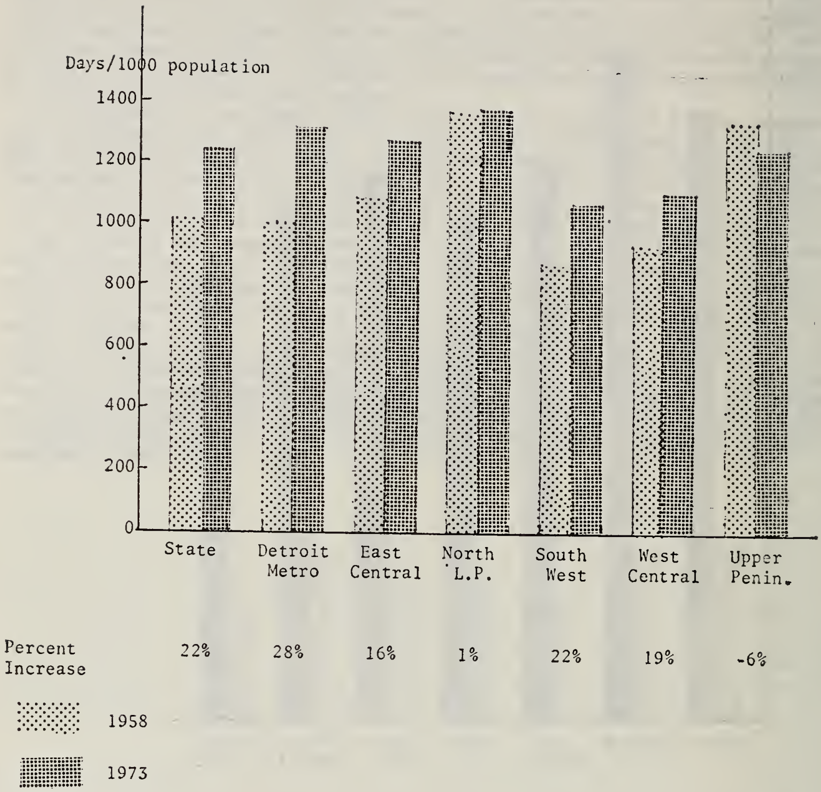


Source: Michigan Blue Cross (1973) and Skinner, C. G., "Hospitals and Allied Institutions," in Hospital Medical Economics, W.J. McNerney, ed., HRET, 1962, p. 776.

FIGURE 2

PATIENT DAY USE RATES IN MICHIGAN

BY REGION, 1958 and 1973



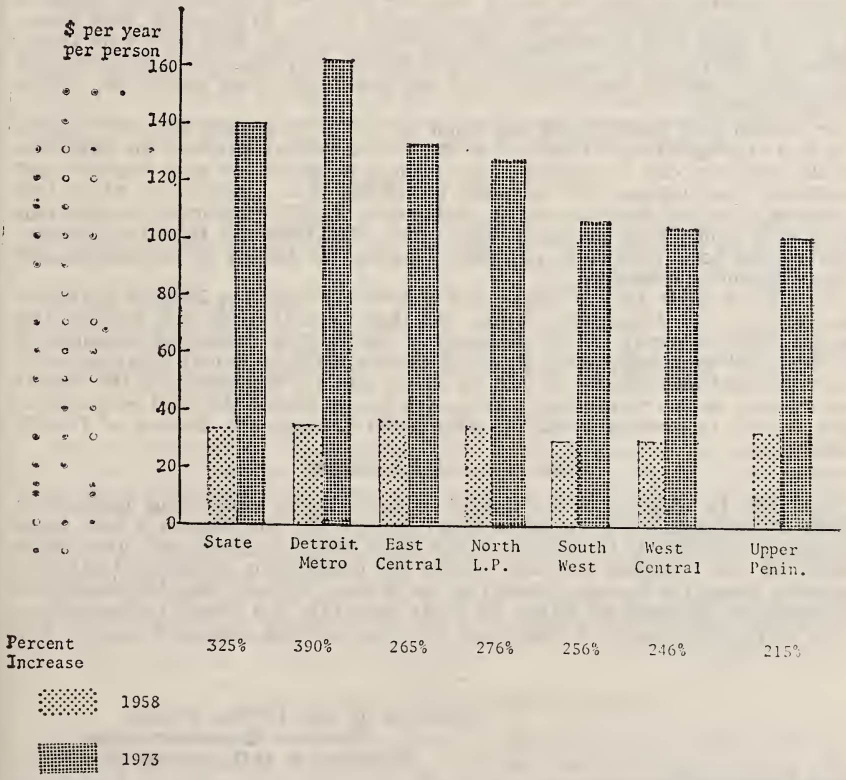
Source: Griffith, J. R. and S. N. Williams, "A New Era in Hospital Management," Michigan Hospitals, J. Michigan Hospital Assoc., May 1976.

Per diem costs, however, are not the sole determinant of insurance premiums or Medicare costs per subscriber. To reach a per subscriber or per person rate, it is necessary to look at the amount of care used in terms of patient days per thousand population (Figure 2). The data indicate that the communities in northern Michigan are very heavy users of care, apparently because of their doctor shortages and rural nature. These areas were high users of care in 1958 and remained high users of care at approximately the same level in 1973. The other areas of the state had varying amounts of increase. Again, the Detroit metropolitan area was the highest with a 28% increase from 1000 to slightly over 1300 patient days of care per thousand population. The east central region incorporating the industrial cities of Flint, Saginaw, Bay City and Midland, is also a high user of care, although its rate of increase is lower because it was one of the highest users of care in 1958 as well. It has had a 16% increase and now uses 1270 patient days per thousand population. The two regions in western Michigan have had about a 20% increase but currently require only 1100 patient days per thousand population. These regions are only now attaining the levels of hospital utilization used in east central Michigan in 1958.

When the use rate and per diem cost factors are combined, it appears that there are very substantial differences in the costs per person. In fact, it appears that the two western regions have inpatient hospital costs of less than $110 per person per year in 1973 while the Detroit metropolitan region was over $160 per person per year, nearly 50 percent higher. The east central area was in between these two figures with more than $130 per person per year. Furthermore, the rates of increase were also dramatically different. Per person costs in the Detroit metropolitan area had increased 390 percent, nearly four times the 1958 level. The areas in western Michigan had increased only about two and a half times the 1958 level (Figure 3). This is still much more than income growth or price index changes, but it is substantially better than many places.

FIGURE 3

ESTIMATED COSTS PER PERSON
HOSPITAL CARE IN MICHIGAN
BY REGION, 1958 and 1973



Source: Griffith, J. R. and S. N. Williams, "A New Era in Hospital Management," Michigan Hospitals, J. Mich. Hosp. Assoc., May 1976.

These geographic areas are quite large and contain within them many different situations. Work is now under way to explore smaller areas and to improve the accuracy of the data. Major findings remain however. In the urban areas utilization of hospitals in Detroit and the eastern cities is substantially higher than that in Kalamazoo, Grand Rapids, and most western cities. The per person cost for a resident of the eastern cities is clearly more than half again the costs for a Grand Rapids resident. The detailed data indicate still more problems. There are, for example, important low use rate areas within the Detroit metropolitan complex, and the highest single use rate community is believed to be Battle Creek in the western part of the state.

There is some "X facor" at work in these communities. I cannot yet identify it, but it would clearly be valuable to know what it is and reward it when we find it again. I am tempted to call the X factor "thrift." It would appear that the regions with the better record have simply been more careful in spending their health care dollars. When I talked to the physicians in some of the low use communities, they say something very close to this. I have shown them the data on patient days per thousand population and asked them why they differ from other communities. Their answer has been, "Because we don't think hospitalization is the answer to every medical problem." I suspect, but cannot prove, that similar conservative attitudes prevail among the trustees and hospital administrators of these "thrifty" communities.

The most important lesson from these data is that per diem based cost control appears to be ill-advised. After adjustment for wage differences, per diem costs are not the most important factor in the cost variation among Michigan cities. Instead the patient day use rate is. The evidence from the New York experiments suggests that controls placed upon per diem costs alone lead to increased utilization, particularly through longer lengths of stay in hospitals. This lesson was well recognized in Michigan by both hospitals and Michigan Blue Cross. When the 1976 cost cap was announced in Michigan by Blue Cross, it was placed upon total inpatient costs rather than per diem costs. This was at the urging of the hospitals.

It is clear that the 1976 cost cap is not the end of Michigan's efforts to control the cost of hospital care. Everyone in the state is acutely aware of the inequities in the 1976 cost cap. It currently only slightly penalizes the most wasteful and inefficient institutions while severely penalizing those institutions which had previously worked hard to control their costs. A 1977 version of the cost cap is already under development by Blue Cross. The Bureau of Hospital Administration has been frequently consulted to gain the benefit of its Section 222 demonstration knowledge.

It appears likely that Michigan will negotiate prospective hospital payments annually for the foreseeable future and that we will refine and improve the equity and sensitivity of the prospective system. The difficulties encountered by Medicaid were regrettable. It would be best if all three major payors could move forward together. To do this, we would need the cooperation of the federal government in two ways, first to revise the law to permit Medicaid cooperation, and second, to provide Medicare cooperation through the Bureau of Health Insurance.

HR 13461, 93RD CONGRESS

Sec. 102. In addition to the method or methods for establishing prospective rates or amounts made available under section 101, the Secretary may make available to hospitals in a State or any other region or geographic area designated by the Secretary another method for establishing prospective rates or amounts where the Secretary finds that the State or regional plan for prospective payment, as developed by either the State, hospitals or a hospital organization, or a third party payor is consistent with the policies expressed in this Act.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., August 12, 1976.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, Rayburn Office Building, Washington, D.C.

DEAR CHAIRMAN ROSTENKOWSKI: In connection with your deliberations on the issue of increased hospital costs and your on-going reexamination of pending proposals for legislative changes in Medicare, I am forwarding you the comments of William J. Skerry, Executive Director, St. Elizabeth's Hospital of

Boston in order that the Committee may have the benefit of Mr. Skerry's views as it considers these pressing matters.

Thanking you in advance for your courtesy in this matter, and with kindest regards, I remain

Sincerely,

James A. Burke,
Member of Congress.

Enclosure.

St. Elizabeths Hospital of Boston,
Boston, Mass., July 13, 1976.

Hon. James A. Burke,
House of Representatives,
Washington, D.C.

Dear Jim: Thank you for your informative reply to my April 27 letter in which I expressed concern about the Medicare and Medicaid cut proposals which were included in the House Budget Committee resolution.

I well understand your interest and that of the Congress in bringing about reforms in the Medicare reimbursement system which will help to contain the increasing costs of the program. I too have a personal interest in doing all that I can to limit the increase in hospital costs. The Board of Trustees and the Administration of this hospital have expended what I think is a mighty effort to limit our own cost increases.

There is much which I could say with regard to reform legislation. I should however like to make just four points which I think should be kept in mind in the working out of this legislation. St. Elizabeth's Hospital, along with many other Massachusetts hospitals, faces serious operating problems which are in part the result of Medicare reimbursement policies and the Commonwealth's approach to the payment of Medicaid and other welfare program benefits. These comments are therefore made in the light of this local situation.

INADEQUATE FINANCIAL BASE

Limitations on reimbursement to Massachusetts hospitals have usually taken the form of ceilings or caps on increases over the existing expense base. Hospitals such as ours which have striven to contain costs are then faced with a reduced expense base to which limits are applied; and these hospitals are therefore doubly penalized.

Such a system does not really provide incentives to cost containment. Incentives should take the form of the hospital's sharing on an ongoing basis in permanent cost reductions which it has been able to effectuate.

SHORT FISCAL PERIODS

Somewhat related to the preceding point is the problem of inadequate reimbursement resulting from events which are beyond the control of the hospital and which affect results of operating in a fiscal year. Cost controls and reimbursement procedures, at least at the local level, fail to give adequate recognition to the concept of the hospital as an operating continuum. Under this concept, the hospital should not be buffeted and penalized by an over-emphasis on operating results in each fiscal year.

Reimbursement reforms should have as one objective the elimination of such penalties. One mechanism for doing this is to provide for the carry forward or carry back of factors which have an atypical effect on a particular year so as to smooth the operating results of the hospital.

INADEQUATE MEDICAID REIMBURSEMENT

Although the purpose of Section 232 of PL 92–603 is to limit title XIX (and title V) reimbursement of reasonable cost to amounts determined for purposes of title XVIII, it would seem that the congressional intent was not to bring about inadequate reimbursement of title XIX services.

A so-called prospective rating system, developed by the Commonwealth and approved by HEW, results in reimbursement which is materially less than reasonable cost and cost determined under title XIX regulations.

FRAGMENTED PAYMENT ARRANGEMENTS

One of the factors which contribute to the escalation medical costs is the absence of a uniform system for payment for hospital services. Each major group of third party purchasers of service has its own payment arrangement. Inadequate payment by some groups, particularly Medicaid, puts upward pressure on payments by others. One of the results is push on the semi-private room charges, one of the components of the consumer price index.

Payment for hospital services should be uniform for all purchasers, including the federal programs, and should be such as to meet all of the financial requirements of the hospital.

I should like to repeat the concern expressed in my first letter, over the financing of improved program benefits through the reduction in reimbursement to hospitals. This violates the principle expressed in point four and increases the financial dilemma in which we find ourselves. The tentative approval of an overall reduction of $25 million in Medicare expenditures for fiscal 1977, which I assume incorporates some of the benefits improvements alluded to in your letter, is heading us in the wrong direction.

I hope that these comments will be helpful in the development of a more equitable reimbursement system.

Very truly yours,

WILLIAM J. SKERRY,
Executive Director.

UNITED SOCIETIES OF PHYSIOTHERAPISTS INC.,
July 28, 1976.

Hon. DANIEL ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, Longworth House Office Building, Washington D.C.

DEAR HON. ROSTENKOWSKI: The United Societies of Physiotherapists, Inc. wishes to thank the members of the Subcommittee on Health for this opportunity to present testimony on the subject of factors contributing to the continuing rise in the costs of hospital care, and more specifically, to the physical therapy component of hospital costs. The following organizations join the United Societies of Physiotherapists, Inc. in this presentation: Council of Licensed Physiotherapists of New York State, Inc., Alan Leventhal, Ph.T., Chairman, 1818 Newkirk Avenue, Brooklyn, N.Y. 11226; New Jersey State Physical Therapy Society, Inc., Patrick Trotta, Ph.T., President 4024 Taylor Road, Fairlawn, New Jersey 07410; Physical Therapy Society of Pennsylvania, Alwen DeWald, Ph.T., President, 1237 Oak Road, Pottsville, Pennsylvania 17901; Golden State Physical Therapy Association of California, Inc. Merlin L. Kemp., Ph.T., President, 809 Chapala Street, Santa Barbara, California 93101; Rhode Island Physical Therapy Society, Inc., Mildred Doane, Ph.T., President, 133 Ansdale Road, Cranston, Rhode Island 02910; and Massachusetts Society of Registered Physical Therapist, Walter Holder, Ph.T., President, 480 Washington Street, Norwood, Massachusetts 02062.

We wish to address ourselves to the topic of the continuing rise in hospital costs, specifically to the physical therapy component of those costs.

There are basically three systems used by hospitals to provide physical therapy services.

1. Salaried departments where all personnel are salaried by the hospital and all equipment and ancillary services are provided by the hospital. Department hours are usually fixed.
2. Contract departments where the hospital enters into an arrangement with an organization to provide physical therapy services. Usually, the equipment and ancillary services are provided by the physical therapy contracting organization. Department hours are flexible and extensive.
3. Hosptials serviced by privately practicing physical therapists who are members of the staff. The private practitioner receives no salary or other fringe benefits but bills the patients directly for services rendered. Equipment, here too, is usually provided by the private practitioner. Department hours are flexible and extensive.

Quality and utilization control mechanisms are not dependent upon the system of physical therapy department utilized but remain the same. The physical therapy department in each instance functions according to the proper legal and hospital requirements.

The salaried department is the least efficient and least productive type of department—and therefore the most costly. The most important item in figuring cost is the cost per unit of work. Salaried departments rate very poorly when this cost mechanism is used.

Contract departments fare better in this regard. As the only monies expended are for actual services rendered, the incentives for efficiency and superior service are higher than salaried departments. We do not here address ourselves to the ethics of contracting professional services to an unlicensed corporate entity. The drawback here is that the hospital is serviced by an organization rather than a professional individual and this tends to render the care somewhat more impersonal but still much better than in salaried departments. Contracting organizations have been severely hampered by being subject to the salary equivilency regulations required by Public Law 92–603 Sec. 251(c). The Bureau of Health Insurance's regulations implementing this section have mandated a time equivalency factor rather than a unit of work factor. This undercuts the whole basis of contracting organizations and makes their operations much more difficult. Senate Bill S. 3611 would tend to alleviate this particular situation by providing an alternative to salary equivilence on the basis of a cost per visit. This is an improvement but by no means solves the problem as it still makes for a most cumbersome reimbursement system with built-in uncertainties for both "provider" and physical therapist and still places the physical therapy practitioner under restrictions applicable to no other licensed health professional.

The private practitioners servicing the hospital provide the same benefits as the contracting organization but on an individual professional basis. Surveys have shown that private practitioners rate very highly among the most experienced and qualified practitioners in the profession. Their practice is built on skill and good results and cannot flourish without satisfying both the patient and the referring physician. Private practitioners allowed by the hospital to practice within its confines bring all their techniques and expertise into their hospital practice. They equip their own departments, absorb all overhead and bill the patients for services rendered. They relieve the hospital from any liability for costs but not from maintaining quality control and utilization control. Prvate practitioners are hampered because Sec. 251(a) of PL 92–603 does not allow for rembursement for their services when performed in a hospital-only when performed in their offices or a patient's home. This is illogical, unfair and leads to unnecessarily increased costs.

We believe the Congress should take action to correct these inequities. Interpretations of 251(c) should be based on unit of work rather than time. Sec. 251(a) should be expanded removing the unrealistic $100 per patient per year limitation and expanding its provisions to cover hospital services. This would allow a free enterprise system in which different systems of physical therapy delivery could compete with each other and institutions, could choose which ever system best suits their needs.

Respectfully submitted,

ALAN LEVENTHAL, PH.T.,
National Legislative Chairman.

STATEMENT OF THE WEST VIRGINIA COMMITTEE FOR THE HEALTH SECURITY ACT

In the April, 1976 issue of "Trustee," a magazine published by the American Hospital Association, an article on page 36 indicates that a Louis/Harris poll commissioned by the Federation of American Hospitals indicated that two-thirds of the American public would be unwilling to pay 10–15% more for hospitalization even if they were guaranteed better quality of service and more personal attention in the hospital. The poll, according to the article, shows that 66% of the public doesn't know why hospital costs are rising.

This is an interesting statement indeed in light of a report recently released by the President's Council on Wage and Price Stability which indicates that the health industry now has "no economic rewards for efficiency and cost reductions, governments pay more than 42% of total costs, the bulk of payments are handled by third parties such as insurance companies, and the doctor determines the nature and extent of services rather than the consumer-patient who is often a passive participant." The point of this is that many of the costs of health care are hidden from the consumer. It would appear, however, by the article in "Trustee" magazine, that the public has become increasingly aware that hospital costs as well as general health care costs are rising and must be controlled at once.

One of the arguments put forward by physicians, hospital administrators and other providers is that proposals such as HR–21, The Health Security Act, and other responsible national health insurance proposals, would violate the free enterprise system on which this country is based. The fact remains, however, as stated in an editorial in the Charleston, West Virginia "Daily Mail" on April 28, 1976, that in medical economics, supply and demand do not interact as they do elsewhere to exercise any restraint upon price. The editorial further states "medical economics remains as it was, a jungle of sorts, where nothing in the interaction of consumer and producers in health care services obeys the laws which apply elsewhere."

The second area which is often attacked by opponents of Health Security Act is that government intervention in the payment mechanism would also violate the free enterprise system and would add to the further increase of costs. These people argue that the country cannot affort a proposal such as the National Health Security Act. This has been the argument of the Nixon and Ford administrations.

The fact remains that it is not that government pays a large portion of the health care costs but the basis on which those payment are made. The current payment based on retrospective repayment is designed by its very nature to add to the cost. The only way that costs can be controlled is to build cost controls into the system itself. It should be increasingly evident that a budgetary cost control program such as provided in the proposed Health Security Act, HR–21, is the way in which this country needs to go.

The Health Security program would establish an advanced budgeting procedure for the cost of personal health services. The program would use the budgetary process not merely to control costs but also to strengthen local, state and regional planning and to stimulate more efficient institutional administration. This seems to me to be one of the major problems which now faces this country in terms of its spiralling health care costs. The Health Security program would thus gradually reverse the current undesirable emphasis on inpatient hospital and other institutional services. This would be done by stressing the preventive and early curative approach to health care and by making alternative levels and forms of care available outside of hospitals.

It is interesting to note that even the Nixon/Ford administration has been a proponent of the HMO approach of prepaid group practice. The very principles on which HMO's are based is to provide early and preventive care and a comprehensive approach to health care and thus to reduce unnecessary and costly hospitalization. Yet the same administration and the same persons, who often propose HMO's for their own benefit, are those who stand in opposition to a program which would bring the same benefits to all the people in the country. If and when payment for services are based on careful projections and planned cost controls and allocated on a budgeted basis, then and only then can we expect to see the rising costs of hospitalization brought into any kind of responsible curtailment.

It is therefore the concern of the West Virginia Committee for the Health Security Act that this Committee of the House of Representatives do all in its power to move to mark-up stage, proposed national health insurance legislation, notably HR–21. The sooner this kind of legislation can be dealt with and moved to passage stage and implemented, the sooner the problem of excessive costs, uncontrolled costs, misuse and abuse of hospitalization and unnecessary surgery can be brought under control. We, therefore, urge this Committee to move with all haste to mark-up stage and toward passage HR–21, The Health Security Act. We feel there is no alternative which can resolve the problems which the hearings being held this date, August 3, address. All too often the Congress has spent its time and the taxpayer's money in hearings well beyond the time when the answers to the question have been clearly stated.

WILLS EYE HOSPITAL,
Philadelphia, Pa., August 2, 1976.

Hon. DANIEL ROSTENKOWSKI,
Chairman, Health Subcommitee, Committee on Ways and Means, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN ROSTENKOWSKI: I was pleased to hear of the Subcommittee's hearing on rising hospital costs and the retrospective cost reimbursement system of the Medicare program. Although I will be unable to testify, I would very much appreciate the Committee taking my written remarks (attached) into consideration on issues Number 1 (cost factor) and 5 (choice of reimbursement methodology).

In addition, I request that you re-examine the underlying premise that Medicare, and specifically retroactive cost-based reimbursement, is the major factor in rising health care costs. I believe Secretary Weinberger's statement on June 12, 1975 to be inaccurate in the extreme. Although I do not have the full text of his remarks available, apparently he failed to take into consideration the inflationary effects of the economy on health care costs as well as two other major factors: the increased number of Medicare recipients; and the increased accessibility to the health care system afforded by federal assumption of reimbursing health care providers for service to people over sixty-five years of age. The continued expectation that health costs will remain fixed or decline in an inflationary economy and with greater numbers of senior people using the system more freely is totally unrealistic. Further, a careful examination of the system reflects that there are adequate cost controls, both retrospective and prospective. These controls, however, are all negative—this is, they penalize poor performance and markedly absent are positive incentives that reward superior performance.

Wills Eye Hospital has over the past two years been able to control its unit costs to remain below regional and national averages because of a rising volume of service and an internal cost reduction program. Therefore, we are in a certain sense responding to the negative incentives of the Medicare program to retard increased costs and in this respect, the Medicare program has contributed to our performance. Aside from the inherent management responsibility to deliver health care to its patients economically—which is considerable—there is no Medicare program incentive to do so. I suggest that the program and its effect would be markedly enhanced if these incentives were provided. I have expanded my thoughts on this subject in my response to issue Number 5, which is attached.

Again, I appreciate the opportunity to share with the Committee my viewpoint and trust that the Committee will defer judgement on prospective cost reimbursement formulas until further research into the source of cost increases, experimentation at the state level with rate review and price setting and its resultant effect on the quality of care, and after positive cost containment formulas are introduced and tested.

Sincerely,

James J. McGee,
Administrator.

ISSUE NUMBER 1

Issue.—Factors contributing to the continuing rise in the costs of hospital care.

Hospital costs are rising because of the economy's impact on labor, equipment and supplies. The increased wage and benefit programs of hospital employees, accelerated by unionization of professional and non-professional employees, in combination with rising prices for food, paper and plastic products, surgical supplies, x-ray films, disposable items, laboratory chemicals, etc., and the increased cost of utilities, only compounds the upward spiral. Under the Medicare program, the increased number of eligible citizens plus the greater accessibility to the system afforded by the financial security of other than the recipient reimbursing the provider, increases overall cost. Under the Medicaid program, the general rise in unemployment increases the number of eligible citizens at the same time it reduces employer underwriting of costs through lesser involvement with commercial insurance programs.

Under these circumstances, the use of retrospective or prospective cost reimbursement formulas are a moot point. The Medicare program has, in fact, both forms within the system already, but their effectiveness is limited by the sources of rising costs. Unless there is a willingness to keep wage and benefit programs below that of other sections of the economy, to control equipment and supply costs to the health care industry below the inflationary factor and to underwrite the impact of medical technology (research through production) outside the hospital, changes in reimbursement formulas are bound to be ineffective. Treating the symptoms of rising costs does *not* work in *any* industry and unless the reality of the cost source is identified and reacted to, the problem will remain and solutions enacted will—in the long run—have an adverse effect on the quality and quantity of care.

ISSUE NUMBER 5

Issue.—The feasibility and desirability of providing to hospitals a choice among more than one reimbursement methodology; the conditions under which it might be desirable to recognize and reimburse in accordance with a State rate-setting program that meets specified criteria.

Fact.—The Medicare Program has both prospective and retrospective cost reimbursement features now, e.g.,: (a) the Institutional Planning Requriement for a three (3) year Capital Budget and Review Program in accordance with Section 234 of the 1972 amendments to the Social Security Act; (b) capital expense items, defined as those projects, items of equipment, etc. exceeding $100,000 in cost must be reviewed and approved by local, regional and state regulatory agencies, established by P.L. 92–603 and P.L. 93–641, before Medicare and Medicaid reimbursement of depreciation and interest expense is authorized; and (c) operating expenses are calculated before the beginning of the fiscal year and an operating budget submitted. After prospective review, reimbursement is paid at an estimated rate throughout the year. The year-end audit then retrospectively determines what "reasonable" costs are reimburseable and what are not.

Fact.—The Medicare Program provides negative incentives against proliferation of services and unnecessary cost increases through its prospective and perspective mechanisms now. Rate setting is another "negative" incentive of far reaching effects which may unintentionally limit the expansion of needed services, adversely effect the quality of care and lead to a bureaucratic approach increasing instead of decreasing cost.

Fact.—The new health planning legislation, P.L. 93–641, has set the requirements and time tables for uniform accounting, reporting and cost allocation systems which are essential prerequisities to rate setting at either the federal or state (prefered) level.

Recommendation.—Further prospective modifications to the Medicare system be deferred until the reporting mechanisms under P.L. 93–641 are established and immediate attention be given to improve the positive incentives to good financial management under the Medicare and Medicaid Programs. For instance, Wills Eye Hospital has over the past six (6) years taken the following action *without* positive financial incentive from the Medicare or Medicaid Program: reduced the number of beds in service from 199 to 120; increased the number of outpatient visits from 65,000 to 105,000; maintained one of the lowest room and board, and outpatient visit rates in the region; and budgetted for and achieved an operational surplus. A competitive incentive to this and other well managed hospitals to encourage this performance could be achieved by:

a. National, state and regional recognition of exceptional community service matched with excellent financial management;

b. Cost reimbursement formulas awarding a cost-plus feature to reward excellent performance which can be documented;

c. Progressively more severe penalties for marginal and poor performance after the positive incentives are in place and evaluated, and the regulatory and uniform reporting provisions of P. L. 93–641 are in effect.

RECOMMENDATIONS RELATING TO REVISIONS IN THE MEDICARE PHYSICIAN REIMBURSEMENT SYSTEM

WEDNESDAY, SEPTEMBER 15, 1976

House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The subcommittee will come to order.

Good morning. I would like to take this opportunity to announce that the hearing on medicare reimbursement for physicians' services in teaching hospitals, which was scheduled for 9 a.m. tomorrow, will begin instead at 8:30 a.m.

The topic of this morning's hearing is the medicare reasonable charge reimbursement for physicians' services.

Under medicare, payment for a physician's service is made on the basis of what is determined to be a reasonable charge for the service provided. This reasonable charge reimbursement system has come under increasing criticism in recent years for failing to satisfy certain objectives.

These objectives include the provision of adequate financial protection for beneficiaries; the promotion of rational payment patterns for physicians' services, and the containment of inflationary tendencies in the program.

The reasonable charge system adopted by the original medicare law was patterned after a physician reimbursement approach widely used in private insurance. One reason this system was thought to be desirable was that it reflected both the customary charges of an individual physician and the charges of physicians generally in the community—thus allowing medicare beneficiaries access to the same quality of care and affording them the same freedom of choice as others in the community.

A series of changes have been made over the years in medicare's rules for determining physician reimbursement. Many of these changes were intended to combat inflationary tendencies. But we have reached the point where reimbursement amounts fall well below the actual charges of many physicians. As a result, there is real concern about how well the present system actually protects beneficiaries.

Also, there is increasing concern that the present system may reinforce irrational urban-rural, regional, and specialty differentials in physicians' charge patterns.

I am hopeful that the subcommittee will acquire from this hearing information to aid us in addressing all these concerns through legislation.

I am inserting in the record at this point the press release announcing today's hearing, and also a briefing document prepared for the subcommittee by the staff on the issues we will be considering today.

[The material referred to follows:]

[Press release of Thursday, July 22, 1976]

HON. DAN ROSTENKOWSKI (D-ILL.), CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS ANNOUNCES A ONE-DAY HEARING ON RECOMMENDATIONS RELATING TO REVISIONS IN THE MEDICARE PHYSICIAN RIEMBURSEMENT SYSTEM, TO BE CONDUCTED WEDNESDAY, AUGUST 25, 1976[1]

The Honorable Dan Rostenkowski (D-Ill.), Chairman of the Subcommittee on Health of the Committee on Ways and Means announced today that the Subcommittee will hold a one-day hearing on the issues involved in increasing physicians' fees and possible revisions in the present reasonable charge reimbursement system used in the medicare program. This hearing will begin at 9:00 a.m. on Wednesday, August 25, 1976,[1] and will be conducted in the Committee's Main Hearing Room, Longworth House Office Building, unless the Committee's schedule at that time necessitates a change of location. A discussion of the specific issues to be considered at this hearing appears below. The hearing will not cover any other subjects or issues. Witnesses will be required to confine their testimony to a discussion of the issues described below and to a precise, detailed explanation of the specific recommendations they are prepared to make for changes in the present medicare reasonable charge reimbursement system.

BACKGROUND INFORMATION REGARDING THE HEARING TOPIC

The primary objectives in determining reimbursement amounts for physicians' services under the medicare program include providing adequate financial protection for beneficiaries, promoting rational payment patterns for physicians' services, and avoiding inflationary tendencies in the program. It is an increasing concern of the Subcommittee that the present system used to determine the amount medicare will pay for a physician's service (the reasonable charge) is not able to address adequately all these objectives.

The reasonable charge system adopted by the original medicare law was similar to some physician reimbursement approaches then in use. One reason this system was thought to be desirable was that it reflected both the customary charges of an individual physician and the charges of physicians generally in the community—thus allowing medicare beneficiaries access to the same quality of care and affording them the same freedom of choice as others in the community. Since the adoption of this system, however, a number of legislative and regulatory refinements have resulted in situations where the reasonable charge is less adequate in reflecting the actual charges of physicians; increasingly, the charge medicare allows is less than the actual charge.

These refinements were intended to address inflationary problems by slowing medicare recognition of rapid increases in physicians' fees; but one result has been to leave the beneficiary to pay the sometimes substantial difference between the medicare reasonable charge and the actual charge of the physician. In addition to concern about the reduced financial protection afforded beneficiaries, there is increasing concern that the present medicare system, by reflecting the actual charges made by physicians, reinforces what have been characterized as irrational urban-rural, regional and speciality differentials in physicians' charge patterns.

SPECIFIC ISSUES TO BE ADDRESSED BY WITNESSES

The Subcommittee desires to receive information and recommendations on a series of specific issues that will need to be addressed in the formulation of a reformed system of physician reimbursement under medicare. Witnesses are invited to address any or all of the following topics:

---

[1] The date of this hearing was later changed to Wednesday, September 15, 1976.

1. Factors in the present medicare reimbursement system which influence physicians' decisions to accept or not accept assignment of claims and any changes which might encourage acceptance of assignment. (Physicians who agree to accept assignment, agree to accept the medicare reasonable charge as payment in full. For an assigned claim, a physician receives payment directly from the medicare program.)
2. Considerations for and against changing present law (under which physicians may choose which claims, if any, they will accept on an assignment basis) to require physicians to accept assignment in all cases as a condition for receiving reimbursement in any case on an assignment basis.
3. Factors contributing to geographic variations in medicare reasonable charges; the rationalty of these geographic variations.
4. Differentials in medicare reasonable charges between urban and rural areas; implications for present efforts to alleviate shortages of physicians in rural areas.
5. Implications of medicare reasonable charge differtials between primary care physicians and other physicians, and between the various physician specialties, including implications for the supply of physicians choosing to practice in various fields.
6. The feasibility and desirability of reimbursement based on fee schedules rather than customary and prevailing charges; the relative roles of government, physicians and others in establishing schedules; the need to adjust schedules for variation in physicians' costs of doing business, speciality status, etc.
7. The role of relative value scales in determining physician reimbursement either under the existing medicare reasonable charge system or another system.
8. Results of experiments or ongoing reimbursement programs which are possible alternatives to or improvements in the present medicare reasonable charge system.
9. Comments on legislation that has been introduced to reform medicare physician reimbursement, such as H.R. 6699 (Fulton), and S. 3205 (Talmadge) and its House counterpart H.R. 13080 (Duncan of Tennessee).

It is the intention of the Subcommittee to reserve for a future time consideration of issues relating to reimbursement for services of hospital-based and teaching physicians, confining the topic of the August 25 hearing to physician reimbursement issues outside those specialized areas.

ALLOCATION OF TIME TO WITNESSES

In view of the limited time available for this hearing. it will be necessary to allocate the amount of time available to each witness for presentation of his direct oral testimony. The witnesses' full statements, as well as any additional materials they would like to submit, will be included in the record of the hearing.

CUTOFF DATE FOR REQUESTS TO BE HEARD

Requests to be heard must be received by the Committee no later than the close of business Wednesday, August 18, 1976. Requests should be addressed to John M. Martin, Jr., Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515, telephone (202) 225–3625. Notification of a witness' scheduled appearance will be made as promptly as possible after the cutoff date. If a witness finds that he cannot appear, he may wish to either substitutes another spokesman or file a written statement for the record.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

Any interested person or organization may, instead of a personal appearance, file a written statement for inclusion in the printed record of the hearing. For this purpose, statements should be submitted in triplicate by the close of business, Wednesday, August 25, 1976. Additional copies may be furnished for distribution to the members of the Committee, the staff, press and interested public, if submitted to the Committee during the course of the public hearing.

REQUESTS TO BE HEARD MUST CONTAIN THE FOLLOWING INFORMATION

1. The name, full address, and capacity in which the witness will appear.
2. A list of persons or organizations the witness represents.
3. A topical outline or summary of the comments and recommendations which the witness proposes to make, such outline or summary to indicate in sufficient detail the nature of the specific recommendations for medicare reimbursement changes the witness intends to make.

Persons scheduled to appear before the subcommittee to testify at this hearing must submit 75 coipes of their prepared statements to the Committee office no later than 24 hours prior to their scheduled appearance. An addiional 50 copies may be furnished for distribution to the press and interested public on the date of appearance.

94th Congress
2d Session

COMMITTEE PRINT

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

REASONABLE CHARGE REIMBURSEMENT FOR PHYSICIANS' SERVICES UNDER MEDICARE

Problems and Alternative Proposals

SEPTEMBER 9, 1976

Prepared by the staff for use by the Subcommittee on Health, House Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
76-296 WASHINGTON : 1976 WMCP : 94-146

COMMITTEE ON WAYS AND MEANS

AL ULLMAN, Oregon, *Chairman*

WILBUR D. MILLS, Arkansas
JAMES A. BURKE, Massachusetts
DAN ROSTENKOWSKI, Illinois
PHIL M. LANDRUM, Georgia
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
JAMES C. CORMAN, California
WILLIAM J. GREEN, Pennsylvania
SAM M. GIBBONS, Florida
JOE D. WAGGONNER, Jr., Louisiana
JOSEPH E. KARTH, Minnesota
OTIS G. PIKE, New York
RICHARD F. VANDER VEEN, Michigan
J. J. PICKLE, Texas
HENRY HELSTOSKI, New Jersey
CHARLES B. RANGEL, New York
WILLIAM R. COTTER, Connecticut
FORTNEY H. (PETE) STARK, California
JAMES R. JONES, Oklahoma
ANDY JACOBS, Jr., Indiana
ABNER J. MIKVA, Illinois
MARTHA KEYS, Kansas
JOSEPH L. FISHER, Virginia
HAROLD FORD, Tennessee

HERMAN T. SCHNEEBELI, Pennsylvania
BARBER B. CONABLE, Jr., New York
JOHN J. DUNCAN, Tennessee
DONALD D. CLANCY, Ohio
BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
WILLIAM A. STEIGER, Wisconsin
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
JAMES G. MARTIN, North Carolina
L. A. (SKIP) BAFALIS, Florida
WILLIAM M. KETCHUM, California

JOHN M. MARTIN, Jr., *Chief Counsel*
J. P. BAKER, *Assistant Chief Counsel*
JOHN K. MEAGHER, *Minority Counsel*

SUBCOMMITTEE ON HEALTH

DAN ROSTENKOWSKI, Illinois, *Chairman*

JAMES C. CORMAN, California
OTIS G. PIKE, New York
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
JOE D. WAGGONNER, Jr., Louisiana
WILLIAM R. COTTER, Connecticut
MARTHA KEYS, Kansas

JOHN J. DUNCAN, Tennessee
PHILIP M. CRANE, Illinois
JAMES G. MARTIN, North Carolina
DONALD D. CLANCY, Ohio

REASONABLE CHARGE REIMBURSEMENT FOR PHYSICIANS' SERVICES UNDER MEDICARE

I. Background

1. Introduction

Under medicare, payment for a physician's service is made on the basis of what is determined, in accordance with medicare law and regulations, to be a reasonable charge for the service provided. This reasonable charge reimbursement system has come under increasing criticism in recent years for failing to satisfy what many people believe should be the primary objectives of a physician reimbursement system under medicare. Specifically, these objectives include the provision of adequate financial protection for beneficiaries, the promotion of rational payment patterns for physicians' services, and the containment of inflationary tendencies in the program.

The reasonable charge system adopted by the original medicare law was patterned after a physician reimbursement approach widely used in private insurance. One reason this system was thought to be desirable was that it reflected both the customary charges of an individual physician and the charges of physicians generally in the community—thus allowing medicare beneficiaries access to the same quality of care and affording them the same freedom of choice as others in the community. Since the adoption of this system, however, a number of legislative and regulatory refinements have resulted in situations where the charge determined to be reasonable by medicare is less than adequate in reflecting the actual charges of physicians; increasingly, the charge medicare allows is less than the actual charge.

Although these refinements were intended to address inflationary problems by slowing medicare recognition of rapid increases in physicians' fees, one result has been that the beneficiary is required to pay the sometimes substantial difference between the medicare reasonable charge and the actual charge of the physician. In addition to concern about the reduced financial protection afforded beneficiaries, there is increasing concern that the present medicare reimbursement system, by attempting to reflect the actual charges made by physicians, also reinforces what has been characterized as irrational urban-rural, regional, and specialty differentials in physicians' charge patterns.

2. Development of the medicare physician reimbursement system

(*a*) *Determination of the reasonable charge*

Services provided by physicians are reimbursed under part B of medicare (supplementary medical insurance) on the basis of what the statute calls the "reasonable charge" for the service provided. The statute requires the carriers* administering part B, when determining the reasonable charge for a particular service provided by a particular physician, to take into account both the individual physician's usual charge for that service (the customary charge) and the charge for that same service generally made by physicians in the community (the prevailing charge). The carriers are to recognize as the reasonable charge the lowest of:

---

*Private organizations with which the Secretary has contracted for the payment of benefits, insurance companies, and Blue Shield.

(i) the physician's customary charge for the service;
(ii) the prevailing charge for that service in that area; or
(iii) the actual charge of the physician.

After the beneficiary has incurred an initial deductible of $60, the plan will pay 80 percent of the reasonable charge; beneficiaries are required to pay 20 percent coinsurance.

In the early years of the program, carriers developed much of their own policy with respect to the specific methods for determining customary and prevailing charges. Since then, central policy direction has been strengthened and a succession of administrative policies and legislative changes have been adopted to provide a greater degree of control on the increasing costs of the program.

The impetus for these changes can, to a large extent, be attributed to the dramatic increases in physicians' fees that took place after medicare went into effect. During the fiscal year 1966–71 period, for example, physicians' fees increased 60 percent faster than the nonmedical items in the Consumer Price Index.

Two of the administrative policies adopted by the program—which were subsequently mandated by the 1972 social security amendments—have been particularly significant in limiting increases in the amounts allowed as medicare reasonable charges. These policies provide that:

(i) The customary charge recognized for a particular physician for a particular service is to be updated each year beginning July 1 and is to be based on the actual charges made by that physician during the preceding calendar year. This creates as much as an 18-month delay in recognizing increases in the physician's customary charge.

(ii) The prevailing charge limit for a particular service in a geographic area is likewise updated each July 1 and is set at the 75th percentile of customary charges made by physicians in that same area for similar services during the preceding calendar year. (Earlier, the prevailing charge limit had been set at the 83d percentile.)

The Social Security Amendments of 1972 included an additional provision which further reflected congressional concern over rising physicians' fees. The provision limits how fast the prevailing charge can increase from year-to-year irrespective of what the 75th percentile amount might be. The prevailing charges recognized in fiscal year 1973 for a locality could be increased in the aggregate in fiscal year 1974 and in later years only to the extent justified by indices reflecting changes in the operating expenses of physicians and in general earnings levels.

Taken together, these changes have led to a situation in which medicare reasonable charges represent less than the going price in a substantial number of cases. Whether, as was intended, the changes have also helped to dampen increases in physicians' fees generally is not known.

(b) Payment methods

Payment for physician services may be made in either of two ways, depending on what the physician wants to do. A physician need not use the same payment method with all patients, and in fact, he can vary the method from time-to-time for a particular patient.

Under one of the methods, the physician agrees to accept assignment and receives directly from the program whatever medicare determines is a reasonable charge for the service provided—less any deductible and coinsurance. The physician must accept the medicare reasonable charge as payment in full, billing the beneficiary only for any deductible and coinsurance amounts. Under the assignment method the physician is assured of payment as a quid pro quo for not billing for more than the reasonable charge.

If the physician does not accept assignment, the program makes payment, based on the medicare reasonable charge for the service, directly to the beneficiary upon receipt of an itemized bill. The physician may bill the beneficiary for any amount he wishes and the beneficiary is financially responsible for the difference between the actual charge of the physician and what he receives from medicare based on the reasonable charge.

II. ISSUES AND PROPOSALS

1. Financial Protection of Beneficiaries

Background

The various limitations on medicare's recognition of increases in physicians' fees have had the effect of increasing out-of-pocket payments required of beneficiaries. This increasing financial burden is a result of two phenomena.

First, there has been a steady decline in the proportion of claims for which physicians accept assignment—from 61 percent in 1969 to 50 in the first 6 months of 1976. Since, when a physician accepts assignment the beneficiary is assured that he will not be responsible for more than the medicare reasonable charge, the assignment rate is a measure of beneficiaries' protection against the cost of physicians' services. The trend in assignment rates is as follows:

Trend in assignment rates

Year:	*Assignment rate*[1] *(percent)*
1968	59. 0
1969	61. 5
1970	60. 8
1971	58. 5
1972	54. 9
1973	52. 7
1974	51. 9
1975	51. 8
1976 (January–June)	50. 1

[1] Excludes hospital-based physicians.

Second, there has been a steady increase over the years in both the percentage of claims which are reduced and the percentage of the reduction. These increases are believed by many to be the reason more physicians are refusing to accept assignment. These trends are as follows:

	1973	1974	1975	1976 (January to June)
Percentage of claims reduced:				
Percentage of total claims reduced	60.6	68.3	74.0	77.5
Assigned	55.6	64.5	70.8	75.3
Not assigned	66.4	72.7	77.4	79.8
Percentage of covered charges reduced:				
Percentage of total charges reduced	12.3	14.5	17.7	19.9
Assigned	11.9	14.3	17.8	20.0
Not assigned	12.6	14.7	17.7	19.7

The declining assignment rate means more beneficiaries are exposed to the responsibility of making out-of-pocket payments (in addition to the deductible and coinsurance), and the increase in the reduction of claims means those out-of-pocket expenditures are increasing.

Proposals

Since physician acceptance of assignment provides assurance to the beneficiary that (after he has met the annual deductible) he will not have to pay any more than 20 percent (the coinsurance) of the medicare reasonable charge, a number of changes in the present program have been suggested to increase the use of the assignment mechanism. These proposals also address one of the primary disadvantages of the present system for beneficiaries whereby physicians are allowed to accept assignment on a random basis; beneficiaries often do not know whether the physician will accept assignment until the service has already been provided.

(*a*) Physicians could be required to accept assignment on an "all or none" basis. Any physician who wishes to participate in medicare would have to agree to accept assignment on all claims; physicians would be designated as "participating" or "nonparticipating" physicians. This concept has been proposed in legislation introduced by Senator Talmadge (S. 3205).

The advantage attributed to this approach is that it would enable a beneficiary to determine in advance of treatment whether the physician would accept assignment and thus what his financial obligation will be.

The concern most often expressed about requiring assignment on an "all or none" basis is that such an approach may encourage many physicians who had previously accepted assignment on some or even most of their medicare claims not to "participate". It is assumed that some may object to such an approach in principle (even though a similar approach is widely used by Blue Shield) while others may find it disadvantageous economically. A beneficiary would still, however, be able to go to a nonparticipating physician, send in his claim himself and be reimbursed directly by medicare.

(*b*) A variation on this approach would be to encourage physicians to become "participating physicians," that is, have physicians commit themselves to accepting assignment on all claims, but allow those physicians who do not accept such a commitment to continue to accept assignment on a random basis. Legislation introduced by Mr. Fulton (H.R. 6699) provides for this system of physician participation.

Under this approach beneficiaries could, for the first time, be given a listing of physicians who will accept assignment in all cases. This approach would eliminate any concerns that a significant number of physicians would refuse to accept assignment on any medicare claims—

as they might under the "all or none" basis. The limitation in this approach is the likelihood, given the absence of any incentives to modify present practices, that many physicians would choose to continue as at present rather than becoming participating physicians.

(*c*) Other proposals, which could be used in conjunction with either of the participating physician concepts described, would provide various types of incentives to make it more attractive for physicians to accept assignment. Assurance of more expeditious processing and payment of claims for participating physicians is one of the suggestions which has been made. For example, the Talmadge bill would allow physicians to submit claims on a simplified and multiple-listing basis rather than on an individual patient basis (as at present) and to receive, within 5 working days, estimated payments of at least 50 percent of the total billing submitted. This is seen as a method of reducing the physician's office administrative overhead and improving his cash flow. In the expectation that this billing method will reduce medicare claims processing costs, the Talmadge bill also provides for a specified payment to participating physicians for each patient claim in each multiple listing of claims.

A variety of other incentives have also been suggested including payment of 85 percent of the reasonable charge when physicians agree to participate instead of the 80 percent payable in all cases under existing law; payment of a reasonable charge based on a percentile of customary charges higher than the present 75th percentile; or payment of 100 percent of the reasonable charge with the medicare program rather than the physician assuming the responsibility of collecting the deductible and coinsurance (as in H.R. 6699). All of these financial incentives, of course, would entail increases in medicare program costs and, in the view of many people, add fuel to existing inflationary pressures.

(*d*) Suggestions have also been made for medicare program recognition of higher fees as a way of increasing beneficiary protection against the cost of physicians' services. It is argued that if this were done physicians would be more willing to accept assignment since a major factor in the physician's decision on whether or not to accept assignment is the difference between medicare's reasonable charge and his actual charge. For those beneficiaries whose physicians still refuse to accept assignments, increasing the fees allowed is virtually the only way to assure that beneficiaries will not have to pay a substantial difference between the reasonable charge and the actual charge.

There are a number of ways of allowing an increase in fees under the medicare program. Some have suggested reducing the present lag in recognizing increases in customary charges. (Customary charges are updated every July 1 based on previous calendar year actual charges.) Another option, as has been mentioned, is to set the prevailing charge limit higher than the 75th percentile. (Commercial health insurance plans generally set the prevailing charge at the 88th to the 90th percentile.) The economic index which limits how much the prevailing charge can increase each year could also be liberalized.

Many are concerned, however, that allowing physicians' fees to increase faster than at present would be inflationary not only for the medicare program but for physicians' fees generally.

2. Payment patterns for physicians' services

Background

(*a*) *Geographic distribution of physicians.*—There is a substantial difference in the availability of physicians to people living in different areas in the United States. Ratios among states range from South Dakota which has only 75 physicians per 100,000 population to New York which has 198 or over twice as many.

Perhaps a more significant comparison is the contrast in the concentration of physicians in urban and rural areas. In 1973, there were 150 physicians per 100,000 population in urban areas, compared with 73 per 100,000 population in nonrural areas. Even within urban centers, however, low-income areas have been shown to have low concentrations of physicians. Recently, the Secretary of HEW designated 384 shortage areas, including rural and inner city areas, as critical physician shortage areas where the physician-to-population ratio was less than 1 physician for 4,000 people.

(*b*) *Specialty distribution of physicians.*—The United States has fewer primary care physicians and more specialists within the physician population than any other developed country. Primary care physicians include general and family practitioners, general internists, and general pediatricians. In 1973, 46 percent of physicians could be designated as primary care physicians.

(*c*) *Medicare and physician choice of location and specialty.*—Many factors affect a physician's choice of specialty and geographic location and it is not clear how much physician income levels and reimbursement rates under health insurance influence these choices. There is a growing concern, however, that regardless of the role financial incentives play in physician distribution, the reimbursement patterns under the medicare program run counter to other Federal efforts to ameliorate the present maldistribution problem.

For example, it is clear that prevailing fees for the same procedure in different counties vary greatly across the United States, even after cost-of-living differences. Contrary to conventional economic theory, high medicare prevailing fees are found in high physician density areas. (The same trend appears to be true for private health insurance payment patterns.) Data indicate that the highest medicare prevailing fees, after cost-of-living adjustments, are in wealthy counties located in large western metropolitan areas, with heavy concentrations of physicians and hospital beds. Lowest fees are most likey to be found in low-income rural midwest counties, scarce in hospital beds and physicians.[1]

Medicare payments for physicians' services have implications for specialty distribution as well as for geographic distribution. One common criticism of third-party reimbursement policies is that they are oriented toward procedures performed and thus discriminate against primary care physicians. (Specialists often are able to bill on the basis of procedure while primary care physicians more often bill on the more general basis of office visits). Indeed, medicare data suggest that there is an economic advantage for procedure-oriented specialists participating in the program. Also, third-party payors have been criticized for allowing surgical fees to advance at a more rapid pace than those for office visits. This is supported by data which shows that, from 1968 to 1972, inflation of medicare fees was greater for procedure-oriented specialties such as general surgery and ophthalmology than for specialties such as internal medicine and general medicine.

---

[1] Data suggests that medicare fees are 16 percent higher in the West, 8 percent higher in the East, 5 percent higher in the South, and 1 percent in the Rockies-Great Plains than in the Midwest.

Proposals

One proposal representing a significant departure from the present medicare reasonable charge system would provide for the use of a fixed-fee schedule. From the standpoint of a third-party payor, the major advantage of a fixed-fee schedule is that estimates of expenditures, and of the premium income required, are less subject to error due to unexpected fee increases. Also, published fee schedules are easy for patients and physicians to understand and easy for the insurance organization to administer. (The inability to determine in advance what a medicare carrier will recognize as a reasonable charge for a particular service is a common complaint of both beneficiaries and physicians.)

On the other hand, health insurance plans with fixed-fee schedules offer no assurance to patients that the allowable fee will adequately cover their medical expenses (unless the physician is obligated to accept the fixed fee as payment in full).

One of the pending bills which would amend the medicare physician reimbursement system (H.R. 6699) would allow each State, at the option of the Governor, to adopt a single fixed-fee schedule for the purposes of medicare reimbursement. The fee schedule is to be proposed by the Governor, after consulting with and receiving recommendations from the State medical society and relevant organizations. The Secretary of Health, Education, and Welfare is to approve the fee schedule if he finds that the total costs incurred under such a schedule are no higher, after adjusting for inflation, than they would have been under the present program.

The single-fee applicable to the entire State represents a way of equalizing medicare fees between urban and rural physicians. Also, this approach would tend to force an explicit decision as to what the relative value of services performed by primary care physicians should be compared to services performed by specialists.

The limitation on statewide program expenditures under this fee schedule proposal would mean an "averaging out" of present fees would have to occur. Urban physicians might have to accept lower fees than at present while rural physicians might receive a fee increase. Since such a fee reduction would very likely be unacceptable to a majority of physicians, it has been suggested that, as an alternative, the highest recognized fees could be held constant (or increased at a slower rate) while the lowest recognized fees could be allowed to increase at a faster rate until they "catch up".

The bill introduced by Senator Talmadge provides for this type of approach to minimizing fee differentials. Statewide prevailing charges (set at the 50th percentile) would be established in addition to the locality prevailing charges. To the extent that any prevailing charge in a locality was more than 50 percent higher than the statewide average charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect—it would operate, to the extent given charges exceed 50 percent of the statewide average, to preclude raising them.

The Senate bill also provides for direct incentives for physicians to practice in rural areas. Charges of physicians would be regarded as reasonable if the service is performed in a shortage area, the physician has a regular practice in the area that was established after the area was declared a physician shortage area, and the charge does not exceed the prevailing charge level for the service.

It should be noted, however, that it is not known whether fee schedules or other forms of reimbursement that are structured so as to offer incentives for physicians to practice in areas of geographic and specialty shortage by themselves directly influence physician behavior. Indeed, the literature suggests that influencing the amount of earnings through changes in the level or structure of fees is not likely to result in an increase in the number of primary care physicians or to affect decisions about where to locate unless other measures are undertaken as well. Those who would suggest structured fee schedules or other reimbursement incentives argue that, regardless of the impact, Federal reimbursement policy should at least be consistent with and support other Federal efforts to ameliorate the maldistribution problem.

3. Inflationary trends in medicare part B

Background

Since the beginning of the medicare program, there has been a concern about the impact of the high rate of inflation in physicians' fees on the expenditures under medicare part B.

During the period 1966–71, annual increases in physicians' fees averaged 7 percent, compared with 4.3 percent for all items in the Consumer Price Index and 6.2 percent for all medical care. During 1972 and 1973, the controls under the economic stabilization program (ESP) reduced this increase to an annual average of 3.2 percent. However, after the ESP controls were lifted, physicians' fees rose sharply, increasing 9.2 percent in 1974 and 12.3 percent in 1975.

Due to various mechanisms to limit fee increases, the rate of increase in fees recognized under the medicare program has not been as rapid as the increases in fees generally. In the year beginning July 1, 1974, however, the medicare reasonable charges began to reflect the sharp increases in physicians' fees following the lifting of the ESP controls. The fee increases recognized for the years beginning in July of 1974, 1975, and 1976 (even with the various medicare controls in place) were 8.4 percent, 7.2 percent, and 10 percent respectively.

Increases in physicians' fees were the most important factor in the 27-percent increase in program expenditures under part B from 1974 to 1975.

Proposals

The administration has proposed a limitation on fee increases under medicare over and above the existing limitations (H.R. 12082). Under this proposal, a physician's reasonable charge for a service could not increase more than 4 percent in the year beginning July 1, 1977, or the following year. Hearings held by the Subcommittee on Health on this proposal reflected a widespread concern that any savings to the program under such a limitation would be borne largely by beneficiaries, as physicians would become even more reluctant to accept assignment.

Under the proposal which would establish a statewide fee schedule for medicare physician reimbursement (H.R. 6699), the yearly increases in fees are tied to the present medicare limitations. The fixed fees in a State would not be allowed to increase more than they would have under the medicare customary and prevailing system. Some have suggested that, in lieu of this, a statewide index could be established to control increases.

Any proposal to further limit medicare recognition of increases in physicians' fees would need to be carefully weighed for its effect on beneficiaries. The greater the disparity between medicare's reasonable charges and the actual charges of physicians, the fewer physicians can be expected to accept assignment and the more beneficiaries will have to pay for physicians' services.

Mr. ROSTENKOWSKI. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

I will be very brief but I would like to extend my welcome to all of the witnesses and thank all of you for the testimony you are about to give.

There is little doubt that the reimbursement of physicians is one of the most significant areas of concern to our subcommittee, as we begin to grapple with the complex, difficult job of bringing meaningful reform to the medicare program.

It certainly is no secret that our health care delivery system looks to the physician as its very backbone. It is therefore extremely important that we find some way of developing practical, workable means of insuring that our medicare beneficiaries receive the care that they require and are entitled to, and at the same time both providing our physicians with the compensation that they deserve and preventing costs from continuing to rise at an unprecedented rate.

The medicare-medicaid reform legislation that I have introduced, H.R. 13080, sets forth proposals that I believe would help solve some of the pressing problems in the administration of medicare.

I would like to say, however, that I certainly would welcome this opportunity to hear other points of view, alternatives, and suggestions. I am certain that all of the testimony today will be most helpful to us.

In fact, the first gentleman here I am sure is going to help us.

Thank you.

Mr. ROSTENKOWSKI. Mr. Symington.

STATEMENT OF HON. JAMES W. SYMINGTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. SYMINGTON. Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. It is certainly a pleasure this morning to come to our committee meeting and address such an outstanding Member and colleague in the Congress.

Certainly, no one has to introduce Jim Symington, who has been an outstanding member of the Interstate and Foreign Commerce Committee as long as I can remember, and he has done a great job.

You may proceed.

Mr. SYMINGTON. Thank you very much, Mr. Chairman.

It is certainly a privilege to appear before you and the members of the committee. I certainly want to congratulate Mr. Duncan for his initiative which I think is highly merited and can lead to some important improvements in the medical situation nationwide.

As a member of the House Public Health and Environment Subcommittee and, as chairman of the Congressional Rural Caucus' Subcommittee on Health, Education and Job Opportunities, Mr. Chairman, I have, over the years, worked toward the enactment of legislation to enlarge the supply and improve the distribution of health professionals.

I might say, parenthetically, that I have reduced my remarks here to five from eight pages in case there is concern about that.

The resultant programs have met with a certain degree of success. The health manpower bill, which recently was reported from conference, continues necessary programs for Federal aid to health professional schools, and includes the incentives for graduates to practice in medically underserved areas of this country.

Along with 25 colleagues in the House, including Mr. Duncan, I have proposed to facilitate the delivery of essential health care services to underserved communities by making a simple, but necessary, revision of the present medicare law.

Our bill, a copy of which I have attached for the hearing record, will amend title XVIII of the Social Security Act to permit reimbursement for services provided by physician extenders.

This concept has been endorsed by the Appalachian Regional Commission and the Southern Governors Conference. I am submitting related attachments for the record.

Currently, one available solution to the distribution crisis is blocked because physician extender services are not included within the range of medicare's reimbursable services.

More than 2,800 physician extenders, and other similarly named health care personnel, are available today, having been specifically trained to provide primary and emergency health care.

They practice under written standing orders and the supervision of physicians, but in communities where physicians do not practice full time.

Their care is of proven high quality, and the new health manpower bill would authorize $90 million over a 3-year period for continued PE training programs.

But because their care does not fit medicare's definition of eligible services, a large number of rural and inner-city Americans are not delivered essential health care services.

Without reimbursement, doctors cannot afford to hire PE's. And as more extenders are trained, they will not find jobs available to deliver primary care so critical to the improved health status of underserved communities.

The money authorized for PE training will be labeled "wasteful government spending," and more trained PE's will join the ranks of the unemployed without enactment of this amendment.

Medicare part B and the amendments of 1972 were written before PE services were as widely accepted as they are today. Experience has proven an extender who follows the strict protocols of a physician's written standing orders and careful referral can bring a physician's knowledge, concern, and coverage to an underserved community.

Often, PE's staff satellite clinics, and their services can reduce the number of days spent in hospitals by medically underserved populations. Moreover, with care closer to home, people use more preventive care, and make fewer overnight trips for physicians' services.

Let me point up these important contributions by briefly highlighting a paper by John W. Runyan, Jr., M.D., who is chairman of the University of Tennessee's Department of Community Medicine.

I would ask that Dr. Runyan's entire paper be included as a supplement to my remarks.

Mr. Rostenkowski. Without objection.

Mr. Symington. A study that Dr. Runyan conducted in Tennessee, in Memphis and Shelby County, revealed that in a system of decentralized clinics, operated by physician-backed nurses, there was about a 45-percent reduction in the need for hospitalization with a continuing care program.

The patients served by this program were a high-risk group, those afflicted with diabetes and chronic diseases. As reported by Dr. Runyan:

> The effectiveness of the program for continuing care . . . is reflected in (*a*) the highly significant reduction in vists to the clinics and emergency room; (*b*) the reduction of admissions to the wards of the city hospital for the preventable complications of diabetes; (*c*) the approximately 44 percent reduction in cost of continuing care as compared to the cost of conventional methods in use in the same community; and (*d*) the enthusiastic acceptance of the system by the patients themselves.

But problems arise at times when a clinic is closed to patients. And satellite clinics are not always practical. Dr. Runyan also reported on a system used by the diabetes service at the Los Angeles County University of Southern California Medical Center, where nurse practitioners are employed to provide care at the medical center.

Without satellite clinics, access to care is decreased somewhat, but there is an around-the-clock telephone hotline service, regular appointment and walk-in screening services, and careful recordkeeping for the 8,000 patients. Dr. Runyan's summary of the advantages of this program states:

> Since this system has been in operation, the average number of days spent by a clinic patient in the hospital annually has decreased from 5.6 to 1.7 . . . Total costs of hospitalization during the system's first full year of operation of the Diabetes Service have been reduced by over $3 million. This reduction of hospitalization has resulted in annual savings of $588 per clinic patient.

Thus, it becomes apparent that where physician extenders practice the health status of the community, even high-risk, chronically ill groups, can improve significantly. And with the corresponding reduction in hospitalization, spiralling costs for in-patient care can be substantially cut.

All the data I have seen reveal that PE services can be delivered at the same cost, and often for less than a full-time physician.

Four years ago, pursuant to the Social Security Act amendments, Public Law 92–603, section 222, Congress authorized a detailed study of extender reimbursement.

Unfortunately, this study is just getting underway. Although an increasing amount of data points to the value and quality of PE services, it is a major concern to me that this social security study is just beginning.

According to HEW's forward plan for health, dated August 1976, there is a great deal of support within the Department for expanding extender services.

Without the results of this study, however, which should include "definitive research findings concerning the impact of PE's on health care costs," the Department has not come out solidly behind extenders.

But as stated in the forward plan, "A major reason for the lack of cost data is the fact that many third-party payors, including medicare and medicaid, do not reimburse for the entire range of PE services." That is on page 56.

If they are depending on medicare data, the catch-22 is obvious, the argument is circuitous. It is my hope that the Social Security Administration will expedite completion of this long-overdue study as I am confident it will reveal the cost-effectivenesses as well as the quality of PE care.

The current situation represents a clear inequity for residents of underserved areas. The following example illustrates the case.

Most medicare beneficiaries, 95 percent, are enrolled in part B, voluntary coverage of physician and outpatient services. If a beneficiary is cared for by a PE in a physician's office, the outpatient department of a hospital, an emergency room, or in any other setting where a physician is in the building, the beneficiary's claim to medicare will be reimbursed at the usual and customary fee for the service provided.

If the same care is provided in a satellite clinic, for which a physician provides remote supervision, the claim will be denied reimbursement.

Thus, a medicare patient, who counts on PE health care services in an otherwise medically underserved area, pays twice for part B services; once out-of-pocket to the extender-staffed clinic, and once in the form of $7.60 per-month premium.

By instituting the change in the medicare law proposed in Mr. Duncan's bill, H.R. 15152, to provide reimbursement for physicians extender services, we will be providing increased access to primary health care for those who qualify, the elderly and disabled.

Because their services are not reimbursable by medicare, the trend for PE's to locate in underserved areas is quite naturally, being significantly curtailed.

Grant money, Federal, State, and private, which has supported extender clinics expires this year for many projects. Medicare reimbursement could greatly improve these clinics chances for financial self-sufficiency.

The Regional Development Act of 1975 authorizes eight regional commissions: Appalachia, Four Corners, Coastal Plains, New England, Upper Great Lakes, Old West, and Ozarks, to develop new clinics.

Without changes in medicare's physician reimbursement policy, these clinics, like so many other federally subsidized projects, may well be forced to shut down when their grants expire.

And should these clinics fail, we will have disappointed communities which have come to rely on their services, and wasted the taxpayers' money.

Finally, if we are to move toward any sort of national health insurance program, we must be prepared to deliver, as inexpensively and directly as possible, quality health care to otherwise medically indigent Americans, regardless of where they live.

A significant contribution to the groundwork for NHI would be laid if we could now amend the medicare law to provide the reimbursement for the primary health care services provided by physician extenders.

I thank the chairman and committee for this opportunity to make those observations.

[The prepared statement and attachment follow:]

STATEMENT OF HON. JAMES W. SYMINGTOM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

REVISIONS IN THE MEDICARE PHYSICIAN REIMBURSEMENT SYSTEM; THE NECESSITY FOR REIMBURSEMENT OF SERVICES PROVIDED BY PHYSICIAN EXTENDERS

Mr. Chairman, thank you for the opportunity to testify on revisions in the Medicare physician reimbursement system.

As a member of the House Public Health and Environment Subcommittee and as Chairman of the Congressional Rural Caucus' Subcommittee on Health, Education and Job Opportunities, I have, over the years, worked toward the enactment of legislation to enlarge the supply and improve the distribution of health professionals. The resultant programs have met with a certain degree of success. The Health Manpower bill, which recently was reported from conference, continues necessary programs for federal aid to health professional schools, and includes incentives for graduates to practice in medically underserved areas of this country.

The continued existence of physician shortages in rural and inner-city communities is no secret, nor are we wanting for proposed solutions. However, most of the solutions cope with, rather than change the source of the problem. For example, the National Health Service Corps program, which places health personnel in medically underserved areas, provides short-term help. But the NHSC program has made little difference in correcting geographic maldistribution. In 1974, the retention rate was estimated at only 20 percent. Nevertheless, the purpose of the Corps is not to provide services indefinitely, but to make those communities which receive Corps personnel self-sufficient. Once a community is familiar with medical services, it may very well take the initiative to maintain the facilities and try to establish a resident staff.

For any number of reasons, doctors are reluctant to locate in underserved communities. Thus, we as legislators, and communities in need of medical care, must look beyond the traditional answer of securing "town doctors." Again, this option copes with, rather than changes the source of the problem.

Along with 25 colleagues in the House, including Mr. Duncan, I have proposed to facilitate the delivery of essential health care services to underserved communities by making a simple, but necessary revision of the present Medicare law. Our bill, a copy of which I have attached for the hearing record, will amend Title XVIII of the Social Security Act to permit reimbursement for services provided by physician extenders. This concept has been endorsed by the Appalachian Regional Commission and the Southern Governors Conference. (Attachments for the record)

Physician extenders often work where doctors are reluctant to practice. Doctors want to work in communities with educational and social amenities for their families. They want close access to specialists, and affiliations with research centers. Recognizing these factors, we cannot expect sufficient numbers of doctors to establish practices in medically underserved areas throughout the country. This is not to say we should not continue to provide incentives for doctors to locate in underserved communities. But we cannot rely on doctors' altruism, and programs like the National Health Service Corps, for lasting improvements in the distribution of quality health care services.

Currently, one available solution to the distribution crisis is blocked because physician extender services are not included within the range of Medicare's reimbursable services. More than 2,800 physician extenders, and other similarly-named health care personnel, are available today, having been specifically trained to provide primary and emergency health care. They practice under written standing orders and the supervision of physicians, but in communities where physicians do not practice full-time. Their care is of proven high quality, and the new Health Manpower bill would authorize $90 million over a three-year period for continued PE training programs. But because PE care does not fit Medicare's definition of eligible services, a large number of rural and inner-city Americans are not delivered essential health care services. Without reimbursement, doctors cannot afford to hire PEs. And as more extenders are trained, they will not find jobs available to deliver primary care so critical to the improved health status of underserved communities. The money authorized for PE training will be labelled, "wasteful government spending," and more trained PEs will join the ranks of the unemployed without enactment of this amendment.

Medicare Part B and the Amendments of 1972 were written before PE services were as widely accepted as they are today. Experience has proven an extender who follows the strict protocols of a physician's written standing orders and careful referral can bring a physician's knowledge, concern and coverage to an underserved community. Often, PEs staff satellite clinics, and their services can reduce the number of days spent in hospitals by medically underserved populations. Moreover, with care closer to home, people use more preventive care, and make fewer overnight trips for physicians' services.

Let me point up these important contributions by briefly highlighting a paper by John W. Runyan, Jr., M.D., who is Chairman of the University of Tennessee's

Department of Community Medicine. (I would ask that Dr. Runyan's entire paper be included as a supplement to my remarks.) A study he conducted in Tennessee, in Memphis and Shelby County, revealed that in a system of decentralized clinics, operated by physician-backed nurses, there was about a 45 percent reduction in the need for hospitalization with a continuing care program. The patients served by this program were a high-risk group, those afflicted with diabetes and chronic diseases. As reported by Dr. Runyan:

"The effectiveness of the program for continuing care . . . is reflected in (a) the highly significant reduction in visits to the clinics and emergency room, (b) the reduction of admissions to the wards of the City Hospital for the preventable complications of diabetes, (c) the approximately 44 percent reduction in cost of continuing care as compared to the cost by conventional methods in use in the same community, and (d) the enthusiastic acceptance of the system by the patients themselves."

But problems arise at times when a clinic is closed to patients. And satellite clinics are not always practical. Dr. Runyan also reported on a system used by the Diabetes Service at the Los Angeles County University of Southern California Medical Center where nurse practitioners are employed to provide care at the Medical Center. Without satellite clinics, access to care is decreased somewhat, but there is an around-the-clock telephone hotline service, regular appointment and walk-in screening services, and careful recordkeeping for the 8,000 patients. Dr. Runyan's summary of the advantages of this program states:

"Since this system has been in operation, the average number of days spent by a clinic patient in the hospital annually has decreased from 5.6 to 1.7 . . . Total costs of hospitalization during the system's first full year of operation of the Diabetes Service have been reduced by over $3 million. This reduction of hospitalization has resulted in annual savings of $588 per clinic patient."

Thus it becomes apparent that where physician extenders practice, the health status of the community, even high-risk, chronically ill groups, can improve significantly. And with the corresponding reduction in hospitalization, spiralling costs for in-patient care can be substantially cut.

All the data I have seen reveal that PE services can be delivered at the same cost, and often for less, than a full-time physician. Four years ago, pursuant to the Social Security Act Amendments (P.L. 92–603, Sec. 222), Congress authorized a detailed study of extender reimbursement. Unfortunately, this study is just getting underway. Although an increasing amount of data points to the value and quality of PE services, it is a major concern to me that this Social Security study is just beginning. According to HEW's Forward Plan for Health, dated August 1976, there is a great deal of support within the Department for expanding extender services. Without the results of this study, however, which should include "definitive research findings concerning the impact of PEs on health care costs," the Department has not come out solidly behind extenders. But as stated in the Forward Plan, "A major reason for the lack of cost data is the fact that many third-party payors, including Medicare and Medicaid, do not reimburse for the entire range of PE services." (p. 56) If they are depending on Medicare data, the Catch-22 is obvious. It is my hope that the Social Security Administration will expedite completion of this long-overdue study as I'm confident it will reveal the cost-effectiveness as well as the quality of PE care.

National Health Service Corps field personnel reported that more than half of the rural physicians they contacted refuse to accept assignment, placing the differential between cost and reimbursement on the patient. When patients must pay the differentials, they will avoid care until the last possible moment when the problems are so acute they often require hospitalization. Then care becomes more costly, both to the government for Medicare and Medicaid participants, and for the patient who has no insurance coverage.

The current situation represents a clear inequity for residents of underserved areas. The following example illustrates the case. Most Medicare beneficiaries (95 percent) are enrolled in Part B, voluntary coverage of physician and outpatient services. If a beneficiary is cared for by a PE in a physician's office, the outpatient department of a hospital, an emergency room, or in any other setting where a physician is in the building, the beneficiary's claim to Medicare will be reimbursed at the usual and customary fee for the service provided. If the same care is provided in a satellite clinic, for which a physician provides remote supervision, the claim will be denied reimbursement. Thus, a Medicare patient, who counts on PE health care services in an otherwise medically underserved area, pays *twice* for Part B services; once out-of-pocket to the extender-staffed clinic, and once in the form of $7.60 per month premium.

By instituting the change in the Medicare law proposed in H.R. 15152, to provide reimbursement for physician extender services, we will be providing increased access to primary health care for those who qualify, the elderly and disabled.

Even if this change is incorporated in the Medicare law, many Americans would still be without insurance to cover care administered by extenders. Unless over 65, or disabled, they are without Medicare. Many are hardworking people, but earning enough to get by, and just a bit too much to qualify for Medicaid. Perhaps they are dependent on seasonal work and do not have access to employer-based insurance or cannot afford private insurance. Our proposed amendment to the Medicare law would not directly make physician extender services more readily available to these groups. But it cannot be denied that Medicare policy serves as the prototype for other forms of insurance. Although a few states (Tennessee, North Carolina, West Virginia and Maine) have made efforts to broaden their Medicaid laws' definitions of physicians services to include those provided by extenders under physician delegation, more states would surely follow if Medicare set the example.

Because their services are not reimbursable by Medicare, the trend for PEs to locate in underserved areas is being significantly curtailed. Grant money, federal, state and private, which has supported extender clinics expires this year for many projects. Medicare reimbursement could greatly improve these clinics' chances for financial self-sufficiency. The Regional Development Act of 1965 authorizes eight regional commissions (Appalachia, Four Corners, Coastal Plains, New England, Upper Great Lakes, Old West and Ozarks) to develop new clinics. Without changes in Medicare's physician reimbursement policy, these clinics, like so many other federally subsidized projects, may well be forced to shut down when their grants expire. And should these clinics fail, we will have disappointed communities which have come to rely on their services, and wasted the taxpayers money.

Finally, if we are to move toward any sort of national health insurance program, we must be prepared to deliver, as inexpensively and directly as possible, quality health care to otherwise medically indigent Americans, regardless of where they live. A significant contribution to the groundwork for NHI would be laid if we could now amend the Medicare law to provide reimbursement for the primary health care services provided by physician extenders.

[H.R. 15152, 94th Cong., 2nd sess.]

A BILL TO amend title XVIII of the Social Security Act to authorize payment under the supplementary medical insurance program for services furnished by physician extenders

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 1861(s)(1) of the Social Security Act is amended by inserting immediately before the semicolon at the end thereof the following: "(including physician extender services rendered under the supervision of a physician whether or not such services are rendered in the physician's office or at a place where the physician is physically present)".

"Physician Extender

"(aa) The term 'physician extender' means a physician assistant, nurse practitioner, nurse clinician, or other trained practitioner who has successfully completed a program of study approved by the Secretary, who is holding a valid certificate as a physician assistant issued by the National Commission on Certification of Physician's Assistants or by any qualified successor to the Commission, or who is licensed or otherwise recognized by a State as qualified to provide primary health care services in the State in which such services are rendered.".

Sec. 2. The amendments made by the first section of this Act shall apply with respect to services furnished on or after the first day of the month following the month in which this Act is enacted.

[From Diabetes Mellitus—Fogarty International Center Series on Preventive Medicine, Volume 4. Department of Health, Education, and Welfare, Public Health Service, National Institute of Health, 1976]

IMPROVING THE ORGANIZATION OF CARE FOR THE CHRONICALLY ILL

(By Leona V. Miller, Jack Goldstein, and John W. Runyan, Jr.)

BACKGROUND

Nearly half the population of the United States suffers from one or more chronic disease [8]. This segment of the population is estimated to account for 80 percent of all health care services delivered. If health care costs are to be reduced in any meaningful way, the major stress will have to be in improving health care delivery to the chronically ill. New methods of health care delivery will have to be developed. Pilot programs with representative chronically ill groups will need to be evaluated before widespread changes can be carried out with the total chronically ill population.

Perhaps one of the most representative chronically ill groups are diabetics, as there is hardly an organ system which diabetes may not affect. Organizing systems to deliver care to diabetic patients incorporate, in microcosm, all the problems found in developing systems to care for chronically ill patients in general. For example, the vast majority of admissions to the Diabetes Service at the Los Angeles County University of Southern California Medical Center are not primarily for problems of diabetes management, but rather for other chronic conditions often found among diabetics, such as heart disease, renal disease, pulmonary disease, and neurological problems among others.

The probability that a diabetic will be hospitalized in any one year is 67 percent. The diabetic spends an average of 5.4 days in the hospital each year and loses an average of 15.4 work days per year. Contrast these statistics with that of the nondiabetic. The likelihood that he will be hospitalized is but 12 percent annually. He spends an average of one day in the hospital each year and loses an average of only 5.7 work days (U.S. National Center for Health Statistics). The inability of the health system to respond fully to the diabetic patient's needs affects his life in a variety of ways. Employment may present a challenge to him. Insurance companies, although more liberal in recent years, do exclude health benefits to diabetics (and a variety of other chronic disease groups) under a "preexisting condition" clause which reduces benefits to diabetic subscribers for the first 2 years of a health insurance policy and in many cases provides inadequate benefits thereafter.

The result is that diabetes is not merely a medical diagnosis, but it also inhibits the diabetic in his ability to obtain a better job and often jeopardizes his financial position. The basic problem is to find a way of delivering care to the chronically ill population so that quality of continuing care is more accessible, which in turn may reduce both morbidity and the costs of providing their care. Once a solution is designed for this basic problem, the effect of the collateral problems will be minimized.

CURRENT STATE OF KNOWLEDGE

A number of investigators have acknowledged that the prime utilizers of health care services in this country and elsewhere, are the chronically ill [1]. Little, however, has been accomplished in designing health systems to deal specifically with this group. Because of the economic and political orientation, health delivery systems have developed in a fragmented manner which often do not necessarily meet the needs of the chronically ill. However, there are two models which attempt to deliver care to the chronically ill and the diabetic patient in an organized manner.

The first of these was initiated over 11 years ago in Memphis and Shelby counties [7, 6]. From the start in 1963, this program has been a joint effort of the local Health Department, the City of Memphis Hospital, and the University of Tennessee College of Medicine.

This program's concept of the care of patients with chronic diseases includes two essential ingredients: (a) geographic decentralization of the health care facilities for ready accessibility to the patients, and (b) the use of specially trained nurses guided by protocols with physician and medical center back-up for patient management to these facilities.

There are currently 18 decentralized clinics. Ten are in urban areas and eight in the semi-rural areas; these serve a population of 225,000 out of the county's population of 750,000. Four of these are multipurpose neighborhood health centers, while the remainder are small installations, called "satellites," located in community centers, public schools, and housing developments. A mobile bus extends medical care to more inaccessible places and remains for the entire day in each of five locations. In 1973 over 40,000 visits were made to these facilities by the more than 9,000 chronic disease patients who are in the program. This includes approximately 3,500 diabetic patients. The equivalent of 20 full-time, specially trained nurses provided the maintenance care. The low missed-appointment rate of 5 to 8 percent is a reflection of the easy accessibility of the facilities, the devotion of the nurses administering the care, the excellence of the follow-up system, and the reduced costs to the patients. It contrasts to the 25–50 percent missed-appointment rate in outpatient clinics of the City Hospital.

The flow of the patients from the decentralized locations to the secondary care facilities and back again is expedited by a liaison service. This service is composed of two nurses, one representing the hospital and the other the Health Department. The consulting physicians in the University Medical Center serve as the medical back-up for the liaison nurses and the nurses in the neighborhood clinics and home. These consulting physicians have developed the medical protocols and policies for the program with the cooperation of the nurses delivering the direct care.

Some observations have been made on a subset of the chronic disease population involving 1,006 patients transferred from the city hospital to the decentralized facilities for maintenance care [6]. In this subset, 555 patients had diabetes mellitus. Ambulant care before transfer was primarily in the hospital clinics and in the hospital emergency ward with a combined total of 8,124 visits per 1000 patients per year to these facilities. After transfer there was a shift, as expected, to the decentralized clinics. Combined outpatient department and emergency ward visits fell to 2,585. Some 166 home visits were also made on this subset, an important index of the continuum of care provided and the increased patient contact with health professionals after transfer.

The cost of ambulant care received in the decentralized locations was one-fifth the cost of comparable care rendered in medical center facilities. A visit to a neighborhood clinic cost $4 compared to $20 for a hospital outpatient visit and $35 for an emergency ward visit.

When the pattern of hospitalization for the 2-year period before and after transfer was examined for those with diabetes, a 49 percent reduction in hospital days and a 42 percent reduction in hospital discharges were found (Table 1). The decrease in the hospital days for diabetic acidosis, serious infections, and problems related to peripheral vascular disease, the preventable complications of diabetes, accounted for the larger share of these reductions. The hospital days required for the renal and vascular complications of diabetes showed, on the other hand, a slight increase indicating the limitations of continuing care in altering the course of these progressive, degenerative complications. The increase of 20 percent in this group was due primarily to readmission to patients with advanced and progressive renal insufficiency frequently with multiple complications.

TABLE 1.—MEMPHIS AND SHELBY COUNTY CONTINUING CARE PROGRAM—HOSPITAL UTILIZATION,[1] DIABETIC PATIENTS

	Hospital discharges		Per 1,000 patients per year (hospital-days)				
			Medical	Surgical	Total		Average per admission
	Number	Percent			Number	Percent	
Before transfer[2]	211		1,297	2,022	3,319		15.7
After transfer[2]	123		746	934	1,680		13.6
Reduction	88	42	551	1,088	1,639	49	

[1] Data based on a survey of 555 diabetic patients transferred to decentralized facilities for continuing care between Sept. 1, 1969, and Aug. 31, 1970.

[2] Data based upon hospitalizations 2 yr before transfer and 2 yr after transfer.

The 49 percent decrease in the total costs of the medical care provided in this program as compared to the costs before transfer is due to the use of the less expensive ambulant services and the decrease in hospitalizations (Table 2).

TABLE 2.—MEMPHIS AND SHELBY COUNTY CONTINUING CARE PROGRAM—MEDICAL CARE COSTS ESTIMATES

	Per 1,000 patients per year	
	Before transfer	After transfer
Ambulant and home care: [1]		
Decentralized clinic visits at $4		$24,732
Hospital out-patient visits at $20	$157,380	50,820
Emergency ward visits at $35	9,025	1,540
Home visits at $12		1,992
Laboratory at $24.96	[2] 24,960	24,960
Medications at $54.75	[2] 54,750	54,750
Subtotal	246,115	158,794
Hospital care [3]	331,900	168,000
Total costs	578,015	326,794

[1] Exact figures unobtainable.

[2] Based upon data from 1,006 chronic disease patients including 555 diabetic patients before and after transfer to decentralized facilities.

[3] Based upon data from 555 diabetics before and after transfer to decentralized facilties.

Past studies using health aides, medical students, and nurses, both in the clinic and in the home, indicate favorable acceptance by the overwhelming majority of the patients of this kind of personnel acting in a professional role. In this study, 98 percent of the 662 patients interviewed preferred this care to other choices. Sixty-four percent considered their general state of health had improved since transfer; only 5 percent felt that their health status had worsened.

The effectiveness of the program for continuing care of patients with diabetes mellitus and chronic diseases is reflected in (a) the highly significant reduction in visits to the clinics and emergency room, (b) the reduction of admissions to the wards of the City Hospital for the preventable complications of diabetes, (c) the approximately 44 percent reduction in cost of continuing care as compared to the cost by conventional methods in use in the same community, and (d) the enthusiastic acceptance of the system by the patients themselves.

While the access to health care has been improved and costs reduced in the Memphis program, financial resources are insufficient to make this system more responsive to patients' needs. A patient needing medical advice or care when the neighborhood health clinic is closed can satisfy his need only by appearing at the emergency room. This tends to disrupt the continuity of care so necessary in caring for the chronically ill. The system in use on the Diabetes Service at the Los Angeles County—University of Southern California Medical Center (LAC–USC) has attempted to solve this problem in another manner. Here too, Nurse Clinical Practitioners are employed to provide care to patients. However, this care is provided within the confines of the Medical Center. This tends to make the care somewhat less accessible than that afforded by the Memphis group. However it tries to improve continuity of care by:

1. furnishing a 7-day-a-week, 24-hour hotline telephone service for its patients;
2. offering medical service at all times either on a scheduled basis in the outpatient department or on an unscheduled basis in a special walk-in clinic maintained by the Diabetes Service. Patients coming to this clinic are evaluated and either cared for on an ambulatory basis, or if diagnostic tests warrant, admitted. Unnecessary admissions have been virtually eliminated by the patients being screened in this Diabetic Walk-In Clinic.
3. maintaining up-to-date records of all 8,000 patients followed by the Diabetes Service in specially formuated, condensed ledgers retained on the Diabetes Service. These ledgers are part of an overall information system that not only permits the rapid information retrieval necessary for providing patient care but also permits computerized review of each physician's performance in health care delivery, the performance of the entire Diabetes Service, as well as epidemiological studies of the inpatient population.

A more complete description of the details of operation of this system is contained in the literature [4]. The effect of this system on reducing costs has been extremely impressive (Table 3). Since this system has been in operation, the average number of days spent by a clinic patient in the hospital annually has decreased from 5.6 to 1.7. This figure is not significantly different from the 1-day average of a randomly ill population. It has meant that the probability of a clinic patient being hospitalized in any one year has decreased from .67 to .21. Total costs of hospitalization during the system's first full year of operation of the Diabetes Service have been reduced by over $3 million. This reduction of hospitalization has resulted in annual savings of $588 per clinic patient.

TABLE 3.—LOS ANGELES COUNTY HOSPITAL [1]—DIABETIC HOSPITAL CARE

	Per year		
	Hospital discharges per 1,000 patients	Hospital days average per patient	Hospital cost per patient
1968	670	5.60 [2](5.4)	$840
1970 [1]	208	1.74	261
Reduction	462	3.86	579
Percent	(70)	(70)	

[1] After introduction of communication and information system to improve patient education.
[2] National average.

Unfortunately, health systems for the chronically ill, such as that in Memphis and Shelby counties and the Los Angeles County—University of Southern California Medical Center, are not common. Incentives to increase the efficiency and reduce the cost of health care delivery are lacking.

Some argue that a system of prepaid health care would change these incentives and would stress efficiency and cost control. However, it does not necessarily follow that the health status of the subscribers would also be properly maintained, so any such system would need appropriate surveillance. No single change in the financing of health care can by itself improve health care delivery, control costs, or help in the redistribution of health professionals and facilities, It is the health care organization that is deficient, and this is where research is needed if the system is to become more appropriate and responsive to the needs of our population.

Research is required on how best to focus resources on needs and on how to provide the appropriate financial and other incentives necessary. If incentives are appropriate, income to the health system would be based not on the output of the system, but on the effectiveness of the system. It would be judged on how well a system maintained the health of its population relative to standards established for that population based on disease distribution, age, sex, education, financial status, and other variables that may affect health status.

For this to be accomplished, a major development effort has to be initiated in improving access to information about the health system. Research into understanding the complexity of the present health system and improving it is impeded by an obsolete information system relying principally on the medical record. Numerous articles have been printed on the deficiencies of the medical record [2, 3, 5, 9], but insufficient stress has been placed on the inimical effect this type of documentation has on: delivering care to the patient; monitoring professional performance; maintaining organizational efficiency; and controlling costs.

The use of medical records as the only source of information is effective primarily for the solo practitioner and small groups. It was never designed to be used by large organizations such as hospitals where the need for information contained in the medical record is needed by many diverse users for different purposes, often at the same time. A more automated, better organized system is needed that can deal with large data bases and deliver informatoin more readily to the physician, his chief, the hospital administrator, the planner and the researcher.

To achieve this, research is needed in design and development of improved information systems to capture, store, retrieve, and manipulate data. A new type of health professional with strong technical background will have to be developed who can not only communicate with other health professionals but who can also use mature judgment in designing information systems much as an architect does in building homes.

With the development of new information systems, research into introducing new systems of health care delivery and evaluating them objectively can be expedited.

REFERENCES

1. Brook, RH, FA Appel, C Avery, M Orman, and RL Stevenson 1971. Effectiveness of inpatient follow-up care. N Engl J Med 285:1509–1514.
2. Day, E 1970. Automated health services—Reprogramming the doctors. Methods of information in medicine 9:116–121.
3. Last, JM 1970. Data collection requirements for patient management. Medical Care 8:159–168, supplement.
4. Miller, LV, and J Goldstein 1972. More efficient care of diabetic patients in a county hospital setting. N Engl J Med 286:1388–1391.
5. Reid, MH 1972. Fishing through patient records. Medical Care 10:488–496.
6. Runyan, JW 1973. Decentralized medical care of chronic disease. Clinical Research 21:276. Paper to be published in Transactions of the Association of American Physicians, Vol. 83.
7. Runyan, JW, WE Phillips, O Herring, and L Campbell 1970. A program for the care of patients with chronic diseases. JAMA 211:476–679.
8. Somers, AMR 1971. Health care in transition: Directions for the future. Chicago Hospital Research and Educational Trust, p 20.
9. Tufo, HM, and JJ Speidel 1971. Problems with medical records. Medical Care 9:509–517.
10. United States National Center for Health Statistics, characteristics of persons with diabetes: United States. July 1964–June 1965. Publication No 1000, Series 10, No 40. Washington, DC, Government Printing Office, 1967, p 9.

APPALACHIAN REGIONAL COMMISSION RESOLUTION NUMBER 407

A RESOLUTION CONCERNING MEDICARE REIMBURSEMENT OF PHYSICIAN EXTENDERS

Whereas the 1972 Amendments to the Social Security Act, Public Law 92–603 directed the Secretary of the Department of Health, Education and Welfare to examine the quality, cost and range of health care that can be appropriately delivered by non-physician providers, and to determine the constraints that should be imposed in order to permit Medicare reimbursement for services provided by such persons; and

Whereas in Senate Report 94–278 accompanying the 1975 Amendments to the Appalachian Regional Development Act, the Public Works Committee of the Senate noted, as a serious problem, that present Medicare regulations do not recognize or permit reimbursement for primary health care services provided by a nurse practitioner or other physician extender, unless a physician is physically present; and urged consideration of this problem by the Senate Finance Committee and the appropriate Committee of the House; and

Whereas the Appalachian Regional Commission, together with the Tennessee State Health Department, the North Carolina Office of Rural Health Services, the Kentucky Health Resources Development Institute, the Frontier Nursing Service, the West Virginia Regional Medical Programs, the Tennessee Valley Authority, the United Mine Workers Health and Retirement Funds, the Southern Labor Union, and the Vanderbilt Center for Health Services, among others, have found by trial and careful testing, that physician extenders do provide appropriate primary health care, especially to persons in medically underserved areas, who otherwise would have limited ability to exercise their entitlement to Medicare services; and

Whereas physician extenders are physician assistants, nurse practitioners, nurse clinicians, or other trained practitioners, who have successfully completed a program of study approved by the National Board of Medical Examiners, or who are licensed or otherwise recognized by a State as qualified to provide primary health care services in the State in which such services are rendered; and

Whereas, the Commission and other sponsoring agencies above mentioned have also found the services provided by these physician extenders, who function in organized systems of care (whether or not performing in the office of, or at a place at which a physician is physically present), to be of commendable quality; and

Whereas the above-mentioned agencies have also found that services provided in this manner help to prevent escalation of health care costs for Medicare beneficiaries; and

Whereas, Section 102(a)(3) of the Appalachian Regional Development Act authorizes the Commission to review Federal, State and local public and private programs, and where appropriate, recommend modifications to increase their effectiveness in the Region: Now, therefore be it

Resolved, That the Appalachian Regional Commission recommends that Title XVIII of the Social Security Act, Part B Supplemental Medical Insurance (42 USC 1305), and all such other medical entitlement programs be amended to permit:

(1) Reimbursement for primary health care services provided by physician extenders, as defined above, when the following safeguards are met:

(*a*) The physician extender is functioning in an organized system of care:

(*b*) The physician extender is acting under written standing orders agreed upon by a duly licensed physician (whether or not such services are performed in the office of, or at a place at which such physician is physically present at the time of the specific service); and

(*c*) The physician providing the written orders assumes full legal and ethical responsibility as to the necessity; propriety and quality thereof.

(2) Such reimbursement be provided at a rate commensurate with the service provided rather than according to the provider of care.

(3) Such reimbursement be made to the clinic or sponsoring organization.

Approved: June 22, 1976.

MILTON J. SHAPP,
Governor of Pennsylvania,
States Cochairman.
DONALD W. WHITEHEAD,
Federal Cochairman.

SOUTHERN GOVERNORS APPALACHIAN REGIONAL COMMISSION URGE MEDICARE BENEFITS FOR PHYSICIANS' EXTENDER SERVICES

North Carolina Governor Jim Holshouser expressed gratitude today that both the Appalachian Regional Commission and the Southern Governors' Conference have thrown their weight behind efforts in Congress to make patients receiving primary health care from physicians' extenders eligible for Medicare benefits.

Resolutions were adopted by both the ARC and the Southern Governors at meetings in Williamsburg, Virginia, this week pointing out that present Medicare regulations do not recognize or permit reimbursement for primary health care services provided by a nurse practitioner or other physician extenders.

Calling this a "serious problem," the two organizations urged that legislation be considered by the Senate Finance Committee and the appropriate committees in the House.

Holshouser, who guided the resolution through the SGC, said that it is crucial that this action be taken in Washington.

"More and more people in North Carolina and throughout the country are realizing the need for physician extenders to help them obtain basic health care," he said.

He pointed out that North Carolina's new rural health center program, formulated by Holshouser three years ago to meet the State's severe doctor shortage in rural areas, depends on the use of family nurse practitioners and other physician extenders who work under the supervision of a physician or physicians in nearby cities.

"The success of that program may well hinge on whether older citizens can have their health care taken care of," the North Carolina Governor said.

Of the more than 200 primary health care centers supported financially by ARC in the Appalachian states, 87 are staffed by "physicians extenders"—nurse-practioners, physician assistants and other non-physicians trained to provide health services. These extenders function under physician supervision but, in most cases, at some distance from a physician.

Medicare, and in many states, Medicaid and private health insurance, do not reimburse patients for physician extenders' services unless a physician is physically present. As a result, 25 to 30 percent of the visits to the 87 clinics are not reimbursed.

"Unless the Medicare regulation is changed, these clinics will not survive when ARC support ends," Holshouser said. "Their survival means the difference between care and no care for many small, isolated communities in Appalachia."

The ARC resolution, which was adopted by the Southern Governor's Conference with minor changes, points out that the ARC, Tennessee State Health Department, North Carolina Office of Rural Health Services, Kentucky Health Resources Development Institute, Frontier Nursing Service, West Virginia Regional Medical Programs, Tennessee Valley Authority, United Mine Workers Health Retirement Funds, Southern Labor Union and the Vanderbilt Center for Health Services, among others, "have found by trial and careful testing, that physician extenders do provide appropriate primary health care, especially to people in medically underserved areas who otherwise would have limited ability to exercise their entitlement to Medicare services."

These agencies, said the resolution, have found the services provided by physician extenders to be "of commendable quality."

20. MEDICARE REIMBURSEMENT OF PHYSICIAN EXTENDERS

Whereas, the 1972 Amendments to the Social Security Act. P.L. 92–603, directed the Secretary of the Department of Health, Education, and Welfare to examime the quality, cost and range of health care that can be appropriately delivered by nonphysician providers, and to determine the constraints that should be imposed in order to permit Medicare reimbursement for services provided by such persons; and

Whereas, the Appalachian Regional Commission, the Tennessee State Health Department, the North Carolina Office of Rural Health Services, the Kentucky Health Resources Development Institute, the Frontier Nursing Service, the West Virginia Regional Medical Programs, the Tennessee Valley Authority, the United Mine Workers Health and Retirement Funds, the Southern Labor Union, and the Vanderbilt Center for Health Services, among others, have found by trial and careful testing, that physician extenders do provide appropriate primary health care, especially to persons in medically underserved areas, who otherwise would have limited ability to exercise their entitlement to Medicare services; and

Whereas, physician extenders are physician assistants, nurse practitioners, nurse clinicians, or other trained practitioners, who have successfully completed a program of study approved by the Secretary of Health, Education, and Welfare, or are certified by the National Commission on Certification of Physicians Assistantants or who are licensed or otherwise recognized by a State as qualified to provide primary health care services in the State in which such services are rendered. Now, therefore, be it

Resolved, That the Southern Governors' Conference endorses passage of legislation such as H.R. 14630 and H.R. 15159 so that title XVIII of the Social Security Act, Part B Supplemental Medical Insurance (42 USC 1305), and all such other medical entitlement programs be extended to permit:

(1) Reimbursement for primary health care services provided by physicians extenders, as defined above, when the following safeguards are met:

(a) The physician extender is functioning is an organized system of care;

(b) The physician extender is acting under written standing orders agreed upon by a duly licensed physician (whether or not such services are performed in the office of, or at a place at which such physician is physically present at the time of the specific service); and

(c) The physician providing the written orders assumes full legal and ethical responsibility as to the necessity, propriety and quality thereof;

(2) Such reimbursement be provided at a rate commensurate with the service provided rather than according to the provider of care; and be it further

Resolved, That such reimbursement be made to the clinic or sponsoring organization.

Mr. ROSTENKOWSKI. Thank you, Jim.

The subcommittee recently took a field trip to Knoxville, Tenn., which is in our colleague, John Duncan's, area.

I must say that in the areas we traveled the physician extender was certainly the hub of the community and did one great job.

As a matter of fact, I have been thinking about introducing legislation in this area myself.

I think certainly that the physician extenders proved to be a tremendous asset and really helped the community in improving its health status.

Any questions from our colleagues?

Mr. Duncan.

Mr. DUNCAN. I have no questions.

I thank you, Jim, for an excellent presentation. I can adopt your statement 100 percent as my very own. The chairman did go down to Knoxville and we went via helicopter back into some of the remote areas of eastern Tennessee and I think he was sold on the idea of a physician extender system as he has said previously.

Mr. SYMINGTON. Thank you, Mr. Duncan, very much.

Just a footnote to that. Missouri is not all that far from Tennessee and we have a number of counties without a single practicing physician. It is quite difficult for those people to find health care without having to travel quite a way.

I would think this program would be very helpful to communities like that which are definitely rural.

Mr. ROSTENKOWSKI. Thank you, Jim.

Thank you for joining us this morning.

Mr. Martin.

Mr. MARTIN. I am intrigued by the use of the helicopter as a Congressman extender.

That is all I wanted to say.

Mr. ROSTENKOWSKI. Thank you, Jim.

Mr. SYMINGTON. Thank you very much.

Mr. ROSTENKOWSKI. Mr. Thornton.

Welcome, Ray, to the committee. We are looking forward to your discussion in this area.

STATEMENT OF HON. RAY THORNTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. THORNTON. Thank you very much, Mr. Chairman.

I do appreciate this opportunity to testify before your subcommittee on the medicare physician reimbursement system.

I think it is very encouraging that your subcommittee has developed the initiative to hold these hearings and I do hope that Congress will enact legislation which will eliminate some of the inequities that I believe exist under present law.

Mr. Chairman, I want to begin by saying that I do not consider myself to be an expert in the area of medicare payments.

There are many issues relating to medicare with which I have little familiarity but I do want to share with this subcommittee one matter which is of a great concern to me and to my State, and which I think has the effect of discriminating against people who reside in rural areas, both the physicians and the medicare patients who live there.

In the State of Arkansas, we are divided into five localities for medicare reimbursement purposes. Physicians who practice in area No. 1, which are the two counties in which Little Rock and Fort Smith are located, and which are paid at a higher rate than physicians in any of the other areas and this is graduated downward to the level No. 5, which receives the lowest compensation and which comprises most of the rural counties in the State of Arkansas.

This discrimination discourages physicians from locating in rural areas where the shortage of physicians is most severe and the need for improved medical care is the most pressing.

HEW has asserted that the prevailing charges of physicians in Little Rock and Fort Smith are higher than the prevailing charges of physicians elsewhere in the State, and that the classification of the State into these five localities is required by the provision of the Medicare Act which limits reimbursement to "the prevailing charges in the locality for similar services."

Mr. Chairman, I want to begin by saying I don't think that this provision requires HEW to designate Arkansas as a five-tier classification or that it would prohibit the classification of the entire State as one location for purposes of the reimbursement.

Arkansas Blue Cross-Blue Shield, which is the medicare carrier for the State, has conducted studies which indicate variations in the charges around the State are not so large as to require the designation of more than one locality.

I believe that HEW's regulation defining "locality" is consistent with the designation of our whole State as a single area.

In a very real sense Arkansas is a single locality for medical services, because of a gravitation toward Little Rock where the State's only medical school and most of the largest hospitals and medicare services are presently located.

HEW contends to establish a single locality would discriminate against medicare recipients because reimbursement might be reduced in the class 1 areas and physicians would accept fewer assignments.

The fact is that physicians in area 1 now only accept jointly entitled medicare and medicaid beneficiaries where the acceptance of the assignment is mandatory.

Assuming the correctness of the study supporting that conclusion there would be little if any decrease in acceptance of assignments in these localities resulting from the establishment of a single medical service area.

I would also like to point out the present system discriminates against rural beneficiaries because they pay the same amount into the system for their services. The effect is that by their payment of the same amounts they are subsidizing those people who are in areas which are provided higher reimbursement costs.

I think the discrimination is actually increased because of this subsidy. It is bad enouugh to tell a doctor in my county of Grant County, 30 miles from Little Rock, that he is a class 5 physician and that he must charge—or rather can only be compensated for the care which he provides at a much lower rate than a physician who lives 15 miles away and provides services in the Little Rock area.

It does not seem to me that the effect of this present practice is reasonable. The State of Arkansas has, by the Governor, objected to this practice. The Blue Cross-Blue Shield group has suggested that there should be one district. HEW takes the position that they are not authorized by present law to make the State of Arkansas a single locality, notwithstanding that many other States are designated as single localities.

Mr. Chairman, if it is agreeable, Senator Bumpers has prepared a very useful legal memorandum on the question of the authority of HEW to declare the State of Arkansas a single area and I would like to request unanimous consent that this memorandum be made a part of my testimony.

Mr. Rostenkowski. There is no objection.

It will be so ordered.

[The memorandum follows:]

THE USE OF A STATEWIDE PREVAILING CHARGE LOCALITY IN ARKANSAS FOR PHYSICIAN REIMBURSEMENT UNDER MEDICARE

Under Title XVIII of the Social Security Act, the Secretary of Health, Education, and Welfare is authorized to enter into contracts with insurance carriers for the administration of benefits in the health-insurance program for aged and disabled persons. 42 U.S.C. 1395u. In the contracts, the carriers agree to pay for physicians' services on a reasonable charge basis.

The standards for determining a reasonable charge for services by a physician are stated in Section 1395u (b) (3) (E) :

"In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services."

In general, the prevailing charge for a service is an amount set high enough to cover the full customary charges of the physicians whose billings account for at least 75% of the billings *in a locality* for that service.

The term "locality" is not defined in the statute. The definition is in the regulations promulgated by the Secretary of H.E.W. Title 20, C.F.R., part 405.

The word "locality" is defined in Section 405.505 as follows:

"Sec. 405.505 Determination of 'locality.'

" 'Locality' is the geographical area for which the carrier is to derive the prevailing charges for services. Usually, a locality will be a political or economic subdivision of a State. It should include a cross section of the population with respect to economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain medical care or service, localities may be recognized on a basis constituting medical service areas (interstate or otherwise), comparable in concept to 'trade areas.' Localities may differ in population density, economic level, and other major factors affecting charges for services. Carriers therefore shall delineate 'localities' on the basis of their knowledge of local conditions. However, distinctions between localities are not to be so finely made that a 'locality' includes only a very limited geographic area whose population has distinctly similar income characteristics (e.g., a very rich or very poor neighborhood within a city)."

The above regulation defining "locality" is given in the form of guidelines which are used by the carrier in its determination of a locality within its service area. Medicare Service Manual, Section 5020.1.

Arkansas Blue Cross and Blue Shield, the Medicare carrier for the entire State of Arkansas, has established five localities within the State of Arkansas.

These five Arkansas *localities* consist of the following counties in the State:

1. Pulaski, Sebastian (including Little Rock and Fort Smith).
2. Craighead, Garland, Jefferson, Miller, Union, Washington.
3. Crittenden, Mississippi, Ouachita, Phillips, Pope, Saline.
4. Arkansas, Ashely, Baxter, Benton, Boone, Chicot, Clark, Columbia, Faulkner, Greene, Hot Spring, Independence, Jackson, St. Francis, White.
5. Bradley, Calhoun, Carroll, Clay, Cleburne, Cleveland, Conway, Crawford, Cross, Dallas, Desha, Drew, Franklin, Fulton, Grant, Hempstead, Howard, Izard, Johnson, Lafayette, Lawrence, Lee, Lincoln, Logan, Little River, Lonoke, Madison, Marion, Monroe, Montgomery, Nevada, Newton, Perry, Pike, Poinsett, Polk, Prairie, Randolph, Scott, Sevier, Searcy, Sharp, Stone, Van Buren, Woodruff, Yell.

According to an April 21, 1976, memorandum from Henry J. Hehir, Assistant Bureau Director, Division of Provider and Medical Services Policy, Bureau of Health Insurance, to the Regional Representative in Dallas, Texas, the carriers were directed as follows:

"However, we have always thought that all carriers, with the knowledge and approval of the regional offices, periodically review and refine their locality determinations in carrying out their responsibilities for efficient claims administration and for making reasonable charge determinations. . . . It seems to us that carriers are expected to periodically review the different phases of their operations for effective administration of the program (including locality delineations). Through their awareness of the local conditions, and changes occurring therein, the carriers should be able to identify problem areas and initiate actions to ensure that their operations are consistent with Medicare policies and regulations."

As suggested by the directive and prior to that time, Arkansas Blue Shield initiated a review of the locality delineations in Arkansas as a part of the process of determining reasonable charges. The carrier decided that the entire State of Arkansas should be treated as a single locality.

The five-locality delineation in Arkansas (1) discriminates against physicians in rural areas because it results in lower payments for their services than for the services of physicians in urban and metropolitan areas; (2) encourages lower charges in rural area, thus contributing to the problem of physician shortages in rural areas; and (3) is unfair to enrollees in Part 8 of Medicare who live in rural areas and who pay the same monthly premiums as enrollees elsewhere.

Arkansas Blue Shield has presented demographic information to the Secretary in support of its request, and these data will not be repeated here.

The request by Arkansas to be designated as a single "medical community" is not unique. The following states have been approved as one "locality" by the Secretary:

Alaska, Delaware, District of Columbia, Montana, New Hampshire, North Dakota, South Dakota, Utah, Vermont, and Wyoming.

Tennessee and Rhode Island will be designated as single localities when the annual revisions are made in the Medicare program this year.

Kansas currently has a statewide Medicare locality, excluding the Kansas City area and the demographic data supplied by Arkansas Blue Shield unquestionably demonstrate that other states with one locality have more diverse fee levels than those in Arkansas. (See Arkansas Blue Shield data, pp. 21–26.)

The general purpose of Subchapter XVIII, the Health Insurance for the Aged Act, as expressed in judicial decisions construing the Act, is to insure that adequate medical care is available to the aged *throughout the country.* To this end the Act is to be construed liberally in order to effectuate its legislative purpose and provisions of the Act are to be interpreted in a sensible, nontechnical manner. See *Rastetter* v. *Weinberger*, 379 F. Supp. 170 (D.C. Ariz.), *affirmed*, 419 U.S. 1098 (1974); *Whitman* v. *Weinberger*, 382 F. Supp. 256 (D.C. Va. 1974).

The Secretary's regulations concerning the determination by carrier of reasonable charges for payment of medical and health services constitute a detailed set of principles for the implementation of the broad statutory language of 42 U.S.C. Sec. 1395 *et seq.* The regulations contemplate that the carrier will use its best judgment in its determination of reasonable charges, and correspondingly in its delineations of localities within its service area. Such determinations by the carriers should be approved by the Secretary of H.E.W. so long as they comport with the basic statutory provisions of the Act.

The determination by Arkansas Blue Shield that the State of Arkansas should be considered a single "medical community" or "locality" is within the statutory provisions of the Act and also the generalized locality definition in the Bureau of Health Insurance regulations. It would not be an abuse of discretion for the Secretary to acquiesce in the carrier's determination that Arkansas is one locality. On the contrary the factual showing made by the carrier would amply support such action.

Mr. THORNTON. Mr. Chairman, the adoption of a statewide fee schedule system is endorsed by the Arkansas Comprehensive Health Planning Council, the State legislature, Arkansas Medical Society, and the Arkansas Blue Shield.

In the event that HEW continues in its objection on the basis of a lack of authority in designating our State and other States similarly situated as a single area for purposes of reimbursement, then I think legislation may be required to correct this lack of authority. For that reason in November 1975, immediately following our former colleague, Mr. Fulton's election to the mayorship of Nashville and his resignation from Congress and this committee, I introduced H.R. 10641, which was a similar piece of legislation to the one that Congressman Fulton had previously sponsored.

This bill would permit a State to elect to be treated as a single area for medicare reimbursement purposes upon a certification of that election being made to HEW.

In the event that HEW does not believe that they have the authority to give a single locality treatment to a State such as ours, I would strongly urge that this committee either use the legislative method, which I have sponsored, or some similar method in assuring that authority does exist.

It is truly a great hardship on rural areas in trying to attract competent medical help.

It seems to me that this medicare-medicaid law should not be a disincentive to physicians locating in rural areas of America.

Thank you.

[The prepared statement follows:]

STATEMENT OF HON. RAY THORNTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Thank you, Mr. Chairman, for this opportunity to testify before your subcommittee on the Medicare physician reimbursement system. I commend the Subcommittee for its initiative in holding these hearings, and I hope that in the near future Congress can enact legislation which will eliminate the inequities existing under present law.

I recognize that the Medicare reimbursement system is very complex, and I do not pretend to be familiar with all the areas which the Subcommittee must consider. However, I am familiar with the problems which result from the present reimbursement system in rural areas such as my District and in all of rural Arkansas. I am convinced that the present system discriminates against both physicians practicing in rural areas and the Medicare patients residing there.

Arkansas has been divided by the Department of Health, Education and Welfare and Arkansas Blue Shield, the Medicare carrier for the state, into five localities for Medicare reimbursement purposes. Physicians practicing in counties designated as locality I are reimbursed at higher rates than those practicing in counties in localities II through V with reimbursement declining for each locality grouping.

The net result of this classification is that physicians in Little Rock and Fort Smith—located in the only two counties designated area I—are reimbursed more than physicians practicing in the rural areas of the state. This discrimination acts as a disincentive for physicians to locate in those rural areas, where the shortage of physicians is most severe and the need for improved medical care is the most pressing.

H.E.W. has contended that the prevailing charges of physicians in Little Rock and Fort Smith are higher than the prevailing charges of physicians elsewhere in the state and that the classification of the state into the localities is required by the provision in the Medicare Act which limits reimbursement to "the prevailing charges in the locality for similar services."

Let me say, first, that I am not entirely convinced that the provision quoted requires a 5-tier classification or that it would prohibit the designation of the whole state of Arkansas as one locality for reimbursement purposes. Arkansas Blue Shield, the medicare carrier for the state, has conducted studies which indicate that the variation in prevailing charges of physicians around the state is not so large as to require the designation of more than one remibursement locality, and I believe that H.E.W.'s own regulation defining "locality" is consistent with the designation of the whole state as a single area.

In a very real sense, Arkansas is a single medical service area because of the gravitation toward Little Rock. where the state's only medical school and most of the larger hospitals and specialists are located.

But H.E.W. has contended that to establish a single locality in the state would discriminate against medicare recipients in Little Rock and Fort Smith because reimbursement rates for those Class I areas might be reduced and physicians would accept fewer assignments. However, Blue Shield has prepared statistics which indicate that even now the only assignments accepted by physicians in the Little Rock and Fort Smith areas are those for jointly entitled Medicare and Medicaid beneficiaries, where the acceptance of assignments is mandatory. Assuming the correctness of that study there would be little, if any, decrease in the acceptance of assignments in the Class I localities resulting from the establishment of a single medical service area.

I would also point out that the present system discriminates against rural beneficiaries because they pay the same medicare rates as urban residents even though the reimbursement rates in their locality are lower. H.E.W. contends that the state-wide reimbursement locality would result in urban beneficiaries subsidizing rural beneficiaries. I respond that under the present arrangement rural residents are subsidizing urban beneficiaries.

Senator Dale Bumpers, who has also been very much interested in this problem in our state, has requested his staff to prepare a memorandum on the possibility of adopting a statewide charge locality under the existing law, and I would like to call this excellent research memorandum to the attention of this committee.

I also request permission to submit related material in support of a statewide system which has been prepared by Arkansas Blue Shield.

Notwithstanding the possibility that authority may exist to adopt a one locality system, if H.E.W. will not adopt a one-locality system because of doubts whether it is permissible under present law, then I believe that it is the responsibility of the Congress to modify the reimbursement system to make clear that there was no Congressional intent to discriminate against rural beneficiaries.

In November, 1975, I introduced H.R. 10641 in order to keep before the House, the provisions of H.R. 6699, introduced by a former Member of this Committee, Congressman Fulton of Tennessee.

The purpose of my bill, co-sponsored by Congressman John Paul Hammerschmidt, and later followed by several similar bills, is to grant specific authority to a state to establish a single fee schedule applicable throughout the state. The authority would be approved by H.E.W. upon application of the Governor. The bill would require consultation with state medical societies and limit the total cost to the Federal government under the statewide fee schedule to no more than would have been incurred under the old system.

I am convinced that the adoption of this legislation would eliminate the discrimination against rural areas inherent in the present arrangement. It would complement our national health care goals by encouraging physicians to practice in rural areas and small towns and by improving the health care facilities for our medically underserved rural populations.

Mr. Chairman, in Arkansas the adoption of a statewide fee schedule system is endorsed by the Arkansas Comprehensive Health Planning Council, the State legislature, the Arkansas Medical Society, and Arkansas Blue Shield. I urge the Subcommittee to give careful consideration to the legislation which I have sponsored or to similar provisions as you continue your work in this important area.

Mr. ROSTENKOWSKI. Thank you, Congressman.

Mr. Duncan?

Mr. DUNCAN. I want to thank you. You have touched an important subject in Tennessee as we have different areas in our State, but I actually don't know of anything that would prevent HEW from doing this.

They have never shown me anything that would prevent them from doing exactly what you are talking about.

What would be your thoughts on even a regional system instead of a State?

Mr. THORNTON. Mr. Duncan, my reading of the law is that HEW should have that authority under the present legislation.

My point is that they are not saying they have that authority and they are basing their refusal to reclassify upon an absence of authority and that is the reason I think legislation may be needed in order to encourage them to go either toward a State or regional application.

Mr. DUNCAN. They try to find a reason why they should not do it rather than to find a reason to do it.

Mr. THORNTON. I am afraid that is the answer and that is the reason for calling for legislation.

Mr. DUNCAN. Thank you very much.

Mr. ROSTENKOWSKI. Mr. Cotter.

Mr. COTTER. I want to compliment you on your fine statement.

Mr. THORNTON. Thank you.

Mr. COTTER. Let me ask you, do you have an idea of the variation in fees between the five areas in your State.

Mr. THORNTON. Yes. I have read through statistics, comprehensive statistics on the variation. They range from a call for a doctor, or a visit to a doctor's office being $25 down to $15, I believe.

That is the range on one item, the office visit. That is the one item I recall right now from the background reading.

There is a comprehensive list, an analysis of the fees, and the variations that would exist and the conclusion by Blue Cross-Blue Shield in studying these was that the variation, while significant, was not so large as to invalidate single area designation for the State.

Mr. COTTER. That would appear there to be quite a variation?

Mr. THORNTON. It was a very wide variation. I would like to submit, if I may, in response to your question, the specific item for which that variation occurred, because it might be useful.

Mr. COTTER. Without objection, I would like it to be made a part of the record, Mr. Chairman.

Mr. ROSTENKOWSKI. No objection?

It is so ordered.

[The information follows:]

ARKANSAS TWO-LOCALITY CONFIGURATION DATA

A. Locality I—(Metropolitan—Fort Smith and Little Rock) remains unchanged.

B. Locality II—(Urban/Rural—Rest of State) composed of existing localities 002, 003, 004, and 005.

C. Data Base for Study.

1. Fiscal year 1976 Economic Index Adjusted Prevailing Charges.
2. Current year 1974 Frequency of Services.
3. Thirteen Services.

a. initial office visit—general practitioner
b. routine followup office visit—general practitioner
c. initial hospital visit—general practitioner
d. routine followup hospital visit—general practitioner
e. biopsy, skin—general practitioner
f. routine followup office visit—other specialists
g. initial hospital visit—other specialists
h. routine followup hospital visit—other specialists
i. appendectomy—other specialists
j. hemorrhoidectomy—other specialists
k. cholecystectomy—other specialists
l. repair hernia, inguinal—other specialists
m. unilateral lens extraction—other specialists

D. Prevailing Charges.

	002	003	004	005	Hypothetical locality II
Service:					
a	$25.00	$20.00	$25.00	$15.00	$21.10
b	7.00	7.00	5.90	5.90	6.20
c	23.60	25.00	25.00	25.00	24.60
d	7.00	7.00	7.10	7.00	7.00
e	23.60	11.80	20.00	17.50	22.10
f	8.80	7.00	7.10	8.00	7.70
g	30.00	25.00	25.00	20.00	24.80
h	11.00	7.00	6.00	5.00	6.90
i	285.00	235.80	234.00	300.00	253.60
j	247.60	194.10	159.20	350.00	210.00
k	400.00	353.70	400.00	412.70	395.20
l	247.60	235.80	225.00	235.80	236.0
m	400.00	412.70	440.00	375.00	407.10

	Locality 001			Locality 002			Locality 003			Locality 004			Locality 005			Statewide		
	72	73	74	72	73	74	72	73	74	72	73	74	72	73	74	72	73	74
SPECIAL CATEGORY A																		
Procedure code:																		
9001	$25.00	$25.00	$27.00	$30.00	$20.00	$20.00	$15	$15.00	$15.00	$25.00	$35.00	$25.00			$8.00	$25.00	$25.00	$25.00
9002	75.00	75.00	81.00	25.00	30.00	30.00	25	25.00	25.00	25.00	35.00	50.00				75.00	75.00	81.00
9004	8.00	10.00	11.00	8.00	8.00	10.00	6	7.00	7.00	6.00	7.00	8.00	$5.00	$10.00	8.00	8.00	8.00	10.00
9021	35.00	40.00	45.00	30.00	25.00	30.00	20	25.00	25.00	25.00	25.00	25.00	25.00	25.00	20.00	30.00	35.00	35.00
9022	75.00	65.00	81.00	30.00	31.50	35.00	25	25.00	30.00	25.00	35.00	35.00				60.00	63.00	65.00
9023	10.00	11.00	12.50	10.00	10.00	11.00	7	7.00	7.00	5.00	5.00	6.00	5.00	10.00	5.00	10.00	10.00	11.00
0869																		
3261																		
3375																		
3515	300.00																	
3631	200.00																	
4321	475.00															475.00		
4617																		
5611																		
9027	35.00	40.00	44.00	25.00	20.00	30.00	20	15.00	25.00		25.00	35.00				25.00	30.00	35.00
9028	45.00	50.00	54.00	30.00	30.00	30.00	25	25.00	25.00	50.00	50.00	50.00	35.00	8.00	35.00	40.00	45.00	50.00
0100	15.00	15.00	15.00	12.50	12.50	15.00	12	12.00	12.00	12.00	12.00	15.00				12.50	12.50	15.00
0101	16.00	17.00	19.00	18.00	18.00	18.00	17	17.00	17.00	15.00	15.00	20.00				16.00	17.00	18.50
0358	35.00	36.77	42.00	35.00	40.00	40.00	30	30.00	30.00	35.00	35.00	40.00				35.00	36.77	40.00
0628	9.50	9.50	10.50	6.00	6.00	6.00	6	6.00	6.00	6.00	5.00	8.50				7.50	7.85	8.50
0652	6.75	6.75	7.00	6.00	6.00	6.00	6	6.00	6.00	5.00	5.00	6.00				6.00	6.75	7.00
0726	6.00	6.00	6.00	5.00	6.00	6.00	5	5.00	8.00	5.00	3.00	6.00				5.00	6.00	6.00
0934	5.00	5.00	5.00	3.00	3.15	3.25	3	3.00	3.00	3.00	15.00	4.00		1.50	2.00	4.00	4.00	4.00
9101	15.00	15.00	17.50	15.00	15.75	16.00	15	15.00	15.00	15.00	10.00	16.50				15.00	15.00	16.50
9103	5.00	5.25	6.00	5.00	10.00	10.00	15	4.00	4.00	10.00	10.00	7.50				5.00	5.25	6.00
SPECIALTY CATEGORY B																		
Procedure code:																		
9001	20.00	10.00	15.00	25.00	12.00	10.00	20	10.00	10.00	20.00	12.00	10.00	15.00	10.00	10.00	20.00	10.00	10.00
9002	25.00	25.00	25.00	25.00	25.00	25.00	20	20.00	20.00		25.00	25.00		15.00	15.00	15.00	25.00	25.00
9004	7.00	7.00	8.00	6.00	6.00	7.00	6	6.00	7.00	5.00	5.00	7.00	5.00	5.00	7.00	6.00	6.00	7.00
9021	25.00	25.00	25.00	20.00	20.00	25.00	25	25.00	25.00	25.00	25.00	25.00	20.00	15.00	25.00	25.00	25.00	25.00
9022	35.00	35.00	35.00	30.00	30.00	30.00	7	25.00	25.00	25.00	25.00	35.00	25.00	25.00	25.00	25.00	25.00	30.00
9023	10.00	10.00	10.00	6.00	7.00	7.00		7.00	7.0	6.00	6.00	7.50	6.00	6.00	7.00	6.00	7.00	7.50
0869																		
3261			250.00	200.00	200.00	250.00				200.00	225.00	275.00	175.00	200.00	200.00	200.00	225.00	225.00
3375					150.00	200.00							150.00			150.00	150.00	200.00
3515		400.00	350.00	300.00	300.00	385.00				250.00	350.00	300.00	375.00	300.00	450.00	300.00	300.00	385.00
3631	250.00	200.00	250.00	200.00	200.00	250.00	175			200.00	250.00	200.00	175.00	200.00	175.00	200.00	200.00	250.00
4321																		

	Locality 001			Locality 002			Locality 003			Locality 004			Locality 005			Statewide		
	72	73	74	72	73	74	72	73	74	72	73	74	72	73	74	72	73	74
SPECIAL CATEGORY B—Continued																		
Procedure Code—Continued																		
4617		$400.00	$450.00	$350.00	$360.00	$500.00			$450.00	$350.00	$350.00	$350.00	$350.00	$375.00	$400.00	$350.00	$350.00	$400.00
5611																		
9027	13.00	25.00	25.00	25.00	25.00	25.00	$15	$25.00	25.00	25.00	10.00	25.00	20.00	10.00	15.00	25.00	25.00	25.00
9028		20.00	25.00	25.00	25.00	25.00		35.00		35.00	25.00				20.00	25.00	25.00	25.00
0100	15.00	15.00	15.00	15.00	15.00	15.00	12	12.00	12.50	12.00	15.00	15.00	12.50	12.50	15.00	12.00	12.50	15.00
0101	16.00	17.00	17.00	15.00	15.00	25.00	17	18.00	18.00	15.00	15.00	20.00	17.00	18.00	20.00	16.00	17.00	20.00
3058	35.00	35.00	37.50	30.00	30.00	45.00	30	30.00	30.00	35.00	35.00	45.00	60.00	40.00	45.00	35.00	35.00	45.00
0628		7.00	7.00	6.00	6.00	7.00	6	6.00	6.00	7.00	7.50	8.00	5.00	6.00	7.25	6.00	6.00	7.50
0652	7.69	7.50	7.50	5.00	5.00	7.00	6	6.00	6.00	6.00	6.50	6.50	6.00	6.00	6.00	6.00	6.00	6.50
0726	6.00	6.00	6.00	5.00	5.00	6.00	5	5.00	6.00	6.00	6.00	7.00	5.00	5.00	6.00	5.00	5.75	6.00
0934	3.00	3.08	4.00	3.00	3.00	3.00	3	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
9101	15.00	15.40	17.00	15.00	15.00	15.00	15	15.00	15.00	15.00	15.00	18.00	15.00	15.00	15.00	15.00	15.00	16.00
9103	5.00	5.00	5.00	5.00			5	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00
SPECIALTY CATEGORY C																		
Procedure code:																		
9001	15.00	15.00	17.00	15.00	15.00	15.00	15	10.00	15.00	15.00	15.00	25.00	15.00	15.00	12.50	15.00	15.00	15.00
9002	25.00	25.00	25.00	20.00	20.00	20.00	25	25.00	25.00	30.00	25.00	25.00		15.00	15.00	25.00	25.00	25.00
9004	7.50	8.00	10.00	7.00	7.50	9.00	6	6.00	8.00	6.00	6.00	7.25	5.00	5.00	6.00	7.00	7.00	8.00
9021	30.00	35.00	35.00	25.00	25.00	25.00	20	20.00	25.00	30.00	26.25	25.00	25.00	25.00	25.00	25.00	25.00	30.00
9022	35.00	35.00	40.00	30.00	30.00	32.00	25	25.00	25.00	35.00	35.00	35.00	25.00	25.00	25.00	35.00	35.00	35.00
6023	10.00	10.00	12.00	8.00	8.00	10.00	7	7.50	8.00	7.50	7.50	7.00	5.00	5.00	8.00	8.00	10.00	10.00
0868	500.00	480.00	720.00		430.00	480.00		350.00	350.00							500.00	350.00	720.00
3261	250.00	250.00	275.00	200.00	250.00	285.00	200	225.00	250.00	200.00	225.00	234.00		250.00	300.00	240.00	250.00	250.00
3375	225.00	250.00	270.00	200.00	200.00	250.00	125	200.00	200.00		175.00	182.00		200.00	350.00	200.00	240.00	250.00
3515	400.00	400.00	440.00	350.00	400.00	400.00	300	350.00	400.00	350.00	350.00	400.00	340.00	300.00	450.00	350.00	400.00	430.00
3631	250.00	250.00	275.00	225.00	225.00	250.00	200	250.00	250.00	200.00	200.00	225.00	250.00	250.00	300.00	250.00	250.00	273.00
4321	450.00	475.00	560.00	400.00	425.00	500.00	300	325.00	480.00	450.00	450.00	475.00				425.00	450.00	550.00
4617	450.00	450.00	500.00	400.00	425.00	450.00	350	350.00	385.00	350.00	400.00	365.00	400.00	400.00	330.00	450.00	350.00	500.00
5611	400.00	400.00	425.00	400.00	400.00	400.00	400	400.00	480.00	400.00	400.00	440.00	350.00	350.00	375.00	400.00	400.00	425.00
5027	25.00	25.00	25.00	20.00	20.00	25.00	15	15.00	15.00	30.00	30.00	30.00	25.00	10.00	25.00	25.00	20.00	25.00
9028	35.00	35.00	35.00	25.00	25.00	25.00	25	15.00	25.00	30.00	30.00	30.00	50.00	50.00	50.00	35.00	35.00	35.00
0100	10.00	10.00	13.00	12.50	12.50	15.00	12	12.00	12.00	12.50	12.60	15.00	10.00	15.00	15.00	12.50	12.50	15.00
0101	15.00	16.81	20.00	18.00	18.00	20.00	17	17.00	17.00	25.00	25.00	20.00	15.00	12.00	15.00	20.00	20.00	20.00
0358	44.00	36.77	45.00	30.00	40.00	30.00				35.00	35.00	35.00	25.00	45.00		35.00	40.00	40.00
0628	7.50	6.00	9.50	5.00	6.00	6.00	6	6.00	7.00	7.00	6.00	7.50	6.00	6.00	6.00	6.00	6.00	6.00
0652	5.00		7.50	5.00	7.00	6.00		6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00
0726	6.00	6.00	7.00	5.00	5.00	5.00	5	10.00	10.00	6.00	7.00	6.00	6.00	6.00	6.00	6.00	6.00	6.00
0934	4.00	4.00	5.00	3.00	3.15	3.50	2	2.50	3.00	3.00	3.00	3.50	2.00	3.00	3.00	4.00	4.00	5.00
9101	15.00	15.75	16.00	15.00	15.00	15.00	15	13.00	13.00	15.00	15.00	16.50	15.00	15.00	15.00	15.00	15.00	15.00
9103	5.00	5.25	5.50	10.00	10.00	15.00		4.00	4.00		10.00		5.00			10.00	5.25	5.50

Procedure code explanation

9001	Initial office visit, routine, new patient or new illness, history and examination.[1]
9002	Initial office visit, complete diagnostic history and physical examination.[1]
9004	Follow-up office visit, routine (up to 15 minutes in duration).
9021	Initial hospital visit, complete diagnostic history and physical examination, known patient or chronic condition, including initiation of diagnostic and treatment programs and preparation of hospital records.[1]
9022	Initial hospital visit, complete diagnostic history and physical examination, new patient or major acute illness including initiation of diagnostic and treatment programs and preparation of hospital records.[1]
9023	Follow-up hospital visit, routine.[1]
0868	Fractures—Femur: neck, multiple pinning, with or without external fixation.[1]
3261	Appendectomy (independent procedure).[1]
3375	Hemorrhoidectomy, internal or internal plus external.[1]
3515	Cholecystectomy.
3631	Hernioplasty: herniorrhaphy: herniotomy—Inguinal, unilateral.
4321	Transurethral electroresection of prostate, including control of postoperative bleeding, complete.
4617	Panhysterectomy: total hysterectomy (corpus and cervix).
5611	Extraction of lens, intracapsular, unilateral.[1]
9027	Consultation requiring limited examination of a given system but not requiring a complete diagnostic history and examination, home, office or hospital.
9028	Consultation requiring complete diagnostic history and examination, office, home or hospital.
0100	Chest, single PA teleroentgenogram (full-sized film).
0101	Chest, PA and lateral films.
0358	Upper gastro-intestinal tract (esophagus, stomach, duodenum and upper jejunum).
0628	Complete count, routine.
0652	Cholesterol, total.
0726	Glucose (sugar).
0934	Urine exams—Routine chemical and microscopic.
9101	Electrocardiogram, with interpretation and report.
9103	Electrocardiogram, interpretation only (tracing not done by interpreting physician).

---

[1] Procedures included in both customary charge analysis and prevailing charge exhibits.

ARKANSAS STATEWIDE MEDICARE PREVAILING FEE REQUEST

Issue	HEW position	Cross reference	Carrier position	Cross reference
Impact of Statewide locality on assignment rate of locality I physicians due to lowering of prevailing fee limits.	The proposed change to a single statewide locality would result in lower medicare reimbursement levels in urban localities. This could have a significant adverse impact on beneficiaries out-of-pocket expenses for medical care and could result in further reducing the number of physicians willing to take assignment.	P. 6	The carrier's most current statistics indicate the following locality I assignment rates: Percent Medical specialties ---- 26 General practice ---- 28 Surgical specialties ---- 32 There is substantial evidence to indicate that the conversion to a statewide locality would have virtually no impact on locality I assignment rates since physicians must accept assignment on jointly entitled medicare and medicaid beneficiaries. In Arkansas there are approximately 275 000 medicare beneficiaries including the under age 65 disabled. Medicaid eligibility roles reflect 80,000 or 29 percent of all Arkansas who are covered by medicare are also eligible for medicaid benefits. Therefore, the reduction in locality I prevailing fees will have little or no impact on assignment rates in Pulaski and Sebastian Counties since physicians in these locales are apparently only accepting assignment on jointly entitled medicare and medicaid beneficaries at the present time.	P. 51.
Issues raised in Commissioner Cardwell's letter of Apr. 8, 1976:				
*Definition of locality	The statute does not specifically define locality. The law clearly seeks to have medicare reimbursement rates based on prevailing charges within the patient's own community and clearly assumes that medicare reimbursement will be different from locality to locality if prevailing charges to nonmedicare patients also differ from locality to locality. In this sense then, the State is in fact *not* a single locality. Prevailing charges do differ by at least some measure as between each of the 5 present localities. Granted, the differences are most significant between Little Rock and its environs and the rest of the State.	Pp. 4, 5–6	The carrier's basic premise for justifying conversion to a statewide locality is that Arkansas is a single "medical community" or "trade area" within the generalized locality definition in bureau of health insurance regulations. The carrier points to the State of Kansas which has essentially a statewide locality and to the statewide prevailing fees paid by the medicare B program for railroad retirees in Arkansas as supporting precedents.	Pp. 19, 21–26.
*Acceptance of a 2 locality arrangement	The carrier has been told that a reduction from the currently used 5 localities to 2 localities (metropolitan Little Rock plus the rest of the State) might be possible and consistent with the intent of the law.	P. 5	The acceptance of the 2 locality concept in Arkansas would only serve to perpetuate the already grossly inequitable medicare B reimbursement methodology resulting from the multiple localities in the State. The recognition of 2 localities runs totally contrary to the basic premise that Arkansas is a single medical community.	

*Structure of Arkansas Blue Shield's private programs.	It is noted that where Arkansas Blue Shield provides medical insurance coverage for private commercial firms such coverage follows the medicare arrangement; i.e., variable reimbursement rates depending on prevailing charges within the locality. In the case of Arkansas, such coverage uses the same 5 localities that are followed for medicare. (It should be noted, however, that such commercial coverage is but a small part of Arkansas Blue Shield's overall coverage and that for its own nonmedicare/noncommercial coverage, they work against a single State fee schedule.)	P. 7	The assessment and conclusions drawn by HEW staff regarding this issue are not founded on fact. Arkansas Blue Shield has recognized a statewide locality for physician reimbursement purposes since 1972. The 5 locality concept was only employed under the Blue Shield program for a 4-yr period—1968–72. Arkansas Blue Shield's private, nonmedicare programs cover approximately 570,000 Arkansasans. Usual, customary and reasonable charge contracts (similar to the medicare reimbursement methodologies) represent in excess of 90 percent of all current Blue Shield policies. The remaining 10 percent of Blue Shield policies are indemnity schedule contracts and are also administered on a statewide locality basis. The contention that Arkansas Blue Shield works against the statewide locality structure in its private business is totally inaccurate.	P. 17.
*Rural physicians' ability to increase medicare prevailing by elevating their charge patterns.	Theoretically at least, higher reimbursement rates could be effected for rural areas if practicing physicians in those areas were, of their own volition, to raise their prices. The medicare statute and HEW regulations provide the opportunity for medicare reimbursement rates to follow common practice within a locality. The truth of the matter is that the rural physicians in Arkansas are not prepared to significantly increase their prices generally. What seems to be proposed here is for medicare to pay higher than a prevailing rate within the rural areas—something that seems clearly inconsistent with the intent of the statute as it now stands.	P. 7	The statement that rural physicians can attain medicare reimbursement parity with their urban peers simply by raising their fees is somewhat misleading. With the application of the economic index provision of sec. 224(A) of the 1972 medicare amendments, the prevailing fee limits can only be increased by HEW derived percentages. In fiscal year 1976, the maximum increase recognized by medicare over the 1971 "base" prevailing fees was 17.9 percent. The combined result of the continuation of the 5 locality structure, plus the application of the economic index constitutes a "gross inequity" for Arkansas rural practicing physicians in both relative and absolute terms. Rural physicians' "base fees" in 1971 were significantly lower than prevailing fees for their urban practicing peers. Based on historical fee trends, this margin has narrowed, but the application of the 17.9-percent economic index serves to perpetuate the same relative fee relationships that existed in 1971. Also, in terms of absolute dollars, a 17.9-percent increase on the dasis of a $5 office call in rural Arkansas is significantly less than a like percentage increase when applied to a $7 office visit "base fee" for an urban practicing physician with like training and experience. The conversion to a state-wide locality will essentially rectify this inequitable situation.	P. 27.

ARKANSAS STATEWIDE MEDICARE PREVAILING FEE REQUEST—Continued

Issue	HEW position	Cross reference	Carrier position	Cross reference
HEW approval to change Crawford County from locality V to locality I.	The carrier's locality delineations are an integral part of their reasonable charge determination processes. As such, they are subject to review and approval by the bureau of health insurance to the same extent as all other aspects of the medicare reasonable charge methodology. Ordinarily, regional office review and approval of carrier locality determinations and of proposed minor changes is sufficient. However, where a region feels there is a serious problem, or that a proposed change would have a major impact it should refer the matter to the central office along with its own financings and recommendations.	P. 71	2 Crawford County GP's petitioned BHI directly for a change in their medicare locality designation from area V to area I. The response received by these 2 physicians was that the carrier was solely responsible for assessing the merits of a locality change request and could implement such a change as carrier prerogative. After corresponding with BHI on several occasions, the policy statement listed under the "HEW Position" column was issued to the carrier by the bureau of health insurance.	Pp. 84–85.
			The carrier compiled Crawford County locality change data in accordance with BHI instructions and submitted a recommendation to BHI that this county be changed to locality I based on the carrier's assessment that this case is a classical example of the inequities that exist throughout the State as a direct result of the medicare 5 locality structure. BHI approved this carrier request on July 1, 1976. The carrier feels that the Crawford County locality change approval constitutes a precedent for a uniform conversion of all counties to a statewide medicare prevailing structure.	P. 73; p. 71.

Mr. COTTER. One other thing. Do you know how many States are treated as an entity?

Mr. THORNTON. Well, I can provide that information as well. I may be able to provide that very quickly in part by saying that Alaska, Delaware, the District of Columbia, Montana, New Hampshire, North Dakota, South Dakota, Utah, Vermont, Wyoming, are all single location States, and that Tennessee and Rhode Island are trying to move toward a single State designation.

Mr. COTTER. Well, I can understand a State like Rhode Island, it is so small, that it does not appear to make sense to have two designations within such a State.

I can't see there is that much variation.

Mr. THORNTON. Certainly.

Then you have in the list Montana, Alaska, North Dakota, South Dakota, and Utah, all of which are large States which like Arkansas have a variation between the metropolitan area and a large rural area or areas.

I am not able to explain why some States are classified as a single district.

Mr. COTTER. It does not make sense to me, either.

Mr. THORNTON. The State of Kansas is a single district State with the exception of metropolitan Kansas City, which you know is on the line between Kansas and Missouri.

Mr. COTTER. Thank you very much for a fine presentation.

Mr. ROSTENKOWSKI. Thank you.

Mr. THORNTON. Thank you.

Mr. ROSTENKOWSKI. Next is Dr. Holden and Dr. Beddingfield.

Welcome to the committee, gentlemen. Please identify yourselves and proceed with your testimony. This committee is ready to receive it.

STATEMENTS OF RAYMOND T. HOLDEN, M.D., AND EDGAR T. BEDDINGFIELD, JR., M.D., ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, AMA DEPARTMENT OF LEGISLATION

Dr. HOLDEN. Mr. Chairman, I am Raymond T. Holden, M.D., a practicing physician in Washington, D.C. I am chairman of the board of trustees of the American Medical Association and I am honored and pleased to present on behalf of the association its views on the important subject with which your subcommittee is today concerned.

With me making the AMA presentation is Edgar T. Beddingfield, Jr., M.D., who is in medical practice in Wilson, N.C. Dr. Beddingfield is chairman of the AMA Council on Legislation. Accompanying us is Harry N. Peterson, director of our department of legislation.

May I ask that the full summary and the full statement which we will submit be included in the record, Mr. Chairman.

Mr. ROSTENKOWSKI. Without objection, it is so ordered.

Mr. HOLDEN. Thank you.

At the outset, Mr. Chairman, we want to express, on behalf of all physicians, appreciation for this timely review of physician reimbursement policies under medicare.

The profession is keenly aware of the overall desire of this subcommittee to fulfill its responsibility in seeing that Federal medicare obligations in providing health care for the elderly are fully and properly discharged.

This hearing, centering on one aspect, is just one of a series apparently intending to review many major aspects of the program.

Mr. Chairman, the medical profession is especially concerned, too, for the physician is the primary person having a personal face-to-face relationship with the beneficiary.

To the patient medicare itself is an impersonal faceless bureaurcracy answerable for its inadequacies only through the Postal Service.

Members of the profession, on the other hand, become in reality the visible image of medicare, and they have increasingly become answerable for deficiencies in medicare.

As you review the important question of part B reimbursement under medicare, we would urge that you consider our thoughts as expressed here today.

In fact we have often expressed our views as to the problems inherent in the present medicare reimbursement program.

Positive changes need to be made. Nevertheless, we would also urge you not to base changes upon assumptions which may in fact be inaccurate or incomplete.

It is imperative that changes that are needed be made in a manner which will further the primary objectives as stated by this subcommittee and not further exacerbate existing problems which have developed because of inappropriate statutory provisions and administration of the medicare program.

We would also urge that changes not be hastily enacted but that this subcommittee explore fully not only the benefits but also any detrimental implications of any proposed changes.

We must point out that the subcommittee notice of these hearings contains a series of specific issues which, if enacted according to their tone, would not meet the real issues but would merely compound the problem and only delay the eventual consideration of the real issue of promises versus payment by the Federal Government.

In our detailed statement we address those specific issues as propounded by the subcommittee and expand upon our comments there.

We believe, nevertheless, that the real solution to the subcommittee's concern will occur only when Congress is willing to adopt a policy of reimbursing for services rendered at a level more nearly reflective of usual and customary charges.

This must be a concomitant element of the medicare program if it really is to fulfill a promise to provide medicare beneficiaries access to the same quality of care and affording them the same freedom of choice as others in the community.

Before proceeding further we would briefly like to direct your attention to certain views which appear in the subcommittee notice announcing these hearings. These views, we fear, may reflect misunderstandings of the present medicare system.

One view reflected in the language of the notice says, in part, in speaking of the present physician reimbursement mechanism under medicare:

"Since the adoption of this system, however, a number of legislative and regulatory refinements have resulted in situations where the reasonable charge is less adequate in reflecting the actual charges of physicians; increasingly, the charge medicare allows is less than the actual charge."

It must be recognized that since the enactment of the medicare law Congress has enacted several important amendments to the law. And while the notice may refer to them as "refinements" no euphemism can disguise their true character—plain reimbursement "curtailments."

One result is that a larger responsibility is placed upon the medicare beneficiary.

The Federal Government nonetheless still emphasizes the fact that actual charges can be more than "medicare-recognized" charges.

We must pose the very basic question of how long can Congress "tilt" at a real problem of increasing benefits, increasing the categories of those eligible for coverage and increasing promises to the public while at the same time failing to accept responsibility for correspondingly increased costs?

The other view in the subcommittee notice which gives us concern is the statement that, in the view of the subcommittee, the "refinements" of legislative and regulatory areas pertaining to reimbursement were intended to address inflation "by slowing medicare recognition of rapid increases in physicians' fees."

We must point out that charges recognized under medicare have never led inflation but instead have followed the inflationary spiral.

Moreover, medicare charges by physicians have, as we have pointed out in our detailed statement, been based upon charge data which at times is up to 2 years old and have never been based on current data.

These "refinements" have placed the physician in the position of absorbing increased costs today for increasingly expensive equipment, supplies, salaries, office expenses, liability insurance, continuing education, and personal living expenses, and yet being asked to be satisfied with medicare reimbursement based on yesterday's charges.

The result is obvious. It cannot be surprising that the patient must pay more or, as often happens in part, the real differential between actual charges and medicare recognized charges is shifted to nonmedicare patients.

Mr. Chairman, before Dr. Beddingfield continues the presentation of our summary, I want to take this opportunity to urge you and the members of the subcommittee to review carefully our detailed statement and to consider its recommendations.

Those recommendations, we believe, would, if adopted by Congress, go far in ameliorating presently existing problems of medicare.

Dr. BEDDINGFIELD. Mr. Chairman and members of the subcommittee, at this time I would like to highlight the remaining portions of our more detailed statement.

Most of my comments, brief because of our desire to conform to the committee's time limitations, will be directed toward H.R. 13080, which addresses several of the specific "issues" raised by the subcommittee in its notice.

H.R. 13080, the Medicare-Medicaid Administrative and Reimbursement Reform Act, introduced in the Senate as S. 3205 by Senator Talmadge, is a massive bill which addresses several issues, including physician reimbursement under medicare.

As to those provisions affecting physician reimbursement under medicare, we would direct your special attention to sections 20, 21 and 22 concerning assignments, statewide prevailing charge levels, medicare index restrictions, and physicians' services under medicare.

Section 21 of H.R. 13080 would establish a new assignment mechanism under medicare. It would create two classes of physicians under medicare: "participating" physicians and "nonparticipating" physicians.

A participating physician would be one who entered into an agreement with the Secretary in which the physician agreed to accept medicare reimbursement as payment in full for his services on the basis of an assignment for all his medicare patients.

A nonparticipating physician would not be eligible to accept assignment with respect to any patient.

Certain entitlements are provided under the bill to induce physicians to sign up as participating physicians. As one inducement the participating physician would be permitted to submit claims on a multiple listing basis, rather than on an individual patient basis, and would be allowed $1 as "an admnistrative cost-saving allowance" for each patient listed.

In addition, at least 50 percent of the estimated amount due on each multiple listing claim form would be paid within 5 days of receipt of the physician's claim, subject to later adjustments.

Mr. Chairman, under the current medicare program a physician may accept an assignment or bill directly for reimbursement and he may do so on a patient-by-patient basis.

There is no requirement currently that physicians enter into any formal agreement with the Secretary whatsoever. Under the new proposal, however, the physician would have to determine his method of reimbursement and this would apply to all his medicare patients without exception.

There is no justification for the strict limitations contained in the proposal. Moreover, it is indeed ironic that in order to entice physicians into a participating agreement medicare should have to offer so-called "benefits."

As to the multiple-list billing mechanism, one should assume there would be administrative advantages for medicare and for the physician.

There is no reason, however, why this payment system should not be put into effect immediately under the current billing and payment procedures, if in fact it would operate as an aid in the administration of the program.

The provision for early—or more appropriately, timely—payment is certainly no more than physicians are entitled to and should receive at the present time, without the necessity of statutory mandate.

Other inducements offered in section 21 are only illusory.

Section 22, in part, also would enact an approach which is intended to "encourage" physician acceptance of assignments for pathology and radiology services—but it does so by penalizing the patients if payment is not made through an assignment.

In passing, it should be observed that in seeking to foster acceptance of assignments, H.R. 13080 is itself dichotomous. In one section, section 21, it seeks to provide "inducements" for assignments, while in another, section 20—as will be discussed in a few minutes—it is discourages such use through imposition of future discriminatory payment mechanisms.

Under section 20 of H.R. 13080, a new prevailing charge level would be determined for each State which has two or more "localities" within it.

For such a State, a statewide prevailing charge level shall cover 50 percent—instead of the current 75 percent—of the charges made for similar services in the State.

Based on this determination of the statewide prevailing charge level, a new limitation is then imposed through operation of the Economic Index.

As to the prevailing charge level for a service in a locality, any increase permitted by the economic index cannot be applied if, and to the extent that, the resulting prevailing charge level for such service or procedure would exceed the statewide prevailing charge level by more than one-half.

This procedure could, in many cases, result in a diminution in the reimbursable amount which physicians would receive by virtue of future increases provided under current law.

Section 22 of H.R. 13080 would, in part, establish by law a stringent, objectionable definition of anesthesiology and pathology services.

We object strongly to these modifications. All services of physicians as recognized within the geographical area of the physicians' practice should be recognized as "physicians' services" under medicare.

A strict application of the bill language would have dire consequences with respect to proper recognition of, and payment for, all services of physicians under medicare.

Further provisions of section 22 relate to those physicians performing pathology or anesthesiology services. Although we recognize that this subcommittee has announced it does plan to have later hearings pertaining to what it calls "hospital associated physicians" and medicare reimbursement relating to them, we wish to point out at this time that physicians should not be viewed in special categories for purposes of reimbursement.

All are physicians, and all should be free to arrange fair reimbursement according to an arrangement which is established by them with other parties.

Congress cannot, and should not attempt to, direct physicians' actions nationwide by statute, and should not enact laws directing what services will constitute physician services.

PSRO's were given the charge to determine the propriety of medical services and when they meet proper professional standards.

We oppose, also, the attempt to establish specific statutory limits on physician charges "related to the income or receipts of a hospital." It cannot be assumed that such contractual arrangements necessarily result in excessive fees, nor can it be assumed that equating the physician's "customary charge" with a "reasonable salary" plus additional necessary hospital and physician costs will be an equitable approach.

The foregoing sections of H.R. 13080 should not be considered favorably by the subcommittee.

I would now briefly like to touch upon the issues of differentials in physician reimbursement and fee schedules. Again, I would urge you to you to review our detailed statement for a more complete discussion of the issues.

There has been a great deal of discussion recently about differences in reimbursement by medicare between physicians located in urban areas versus rural areas, as well as differentials in reimbursement made to physicians within various specialties.

We believe that there are valid reasons for differentials among geographic areas as well as among specialties. Medicare itself recognizes that there are differences, as physician reimbursement amounts recognized are to be based upon "localities".

These differences have occurred because of differences in the cost of maintaining a medical practice, differences in the cost of living, and even differences in aesthetic values.

Some physicians are satisfied to serve in environmentally more pleasant surrounding while receiving less income than they could if they served in other areas.

Basically, as to specialties, the reasonableness of a specialist's charge must be judged—as the medicare law now states—in comparison with the charges of physicians of similar training and experience.

We believe that the Federal Government should adopt a policy of reimbursing physician services at the usual and customary charges of that physician for his area.

Such a policy would recognize that while Federal programs can expect the same quality care as private plans, as now occurs, the Federal Government in its programs should assume a comparable obligation for that quality care.

A "fee schedule approach" has been advocated for payment under medicare and has even been included in some of the presently pending national health insurance bills.

However those proposals which would impose such a system, including H.R. 6699 pending before you, are unwise and should not be adopted.

They contemplate a mechanism establishing throughout an area schedules which would limit the total medical health care expenditures.

Although everyone desires to reduce costs wherever possible, a lowering of costs cannot be justified when patient care would be jeopardized.

If fee schedules were introduced, we believe that any reduction in costs would result in further discouraging physician participation and limiting availability of care by reducing patient access to a physician of his choice. Unrealistic limits will affect quality patient care in the medicare program.

Mr. Chairman, we again invite consideration of our full statement. At this time we will be pleased to respond to any questions which the subcommittee may have.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION, PRESENTED BY RAYMOND T. HOLDEN, M.D., AND EDGAR T. BEDDINGFIELD, JR., M.D.

SUMMARY

Mr. Chairman and members of the subcommittee, I am Raymond T. Holden, M.D., a practicing physician in Washington, D.C. I am Chairman of the Board of Trustees of the American Medical Association and am pleased to present on behalf of the Association its views on the important subject with which your subcommittee is today concerned. With me making the AMA presentation is Edgar T. Beddingfield, Jr., M.D., who is in medical practice in Wilson, North Carolina. Dr. Beddingfield is Chairman of the AMA Council on Legislation. Accompanying us is Harry N. Peterson, Director of our Department of Legislation.

At the outset, Mr. Chairman, we want to express, on behalf of all physicians, appreciation for this timely review of physician reimbursement policies under Medicare. The profession is keenly aware of the overall desire of this Subcommittee to fulfill its responsibility in seeing that federal Medicare obligations in providing health care for the elderly are fully and properly discharged. This hearing, centering on one aspect, is just one of a series apparently intending to review many major aspects of the program.

Mr. Chairman, the medical profession is especially concerned, too, for the physician is the primary person having a personal face-to-face relationship with the beneficiary. To the patient, "Medicare" itself is an impersonal faceless bureaucracy answerable for its inadequacies only through the postal service. Members of the profession, on the other hand, become in reality the visible image of Medicare, and they have increasingly become answerable for deficiencies in Medicare.

As you review the important question of Part B reimbursement under Medicare we would urge that you consider our thoughts as expressed here today. In fact we have often expressed our views as to the problems inherent in the present Medicare reimbursement program. Positive changes need to be made. Nevertheless, we would also urge you not to base changes upon assumptions which may in fact be inaccurate or incomplete.

It is imperative that changes that are needed be made in a manner which will further the "primary objectives" as stated by this Subcommittee and not further exacerbate existing problems which have developed because of inappropriate statutory provisions and administration of the Medicare program. We would also urge that changes not be hastily enacted but that this Subcommittee explore fully not only the benefits but also any detrimental implicaions of any proposed changes.

During your hearings you may hear conflicting suggestions as to the appropriate changes which should be made. We would urge you to consider our suggestions, Mr. Chairman and members of the Subcommittee, in the light of two essential aspects.

First, our views are based upon critical examination over a long period of time. The problems which are presently manifested in Part B payments under Medicare are *not* new but have been occurring for several years. Only recently has full attention been directed toward the inherent discrepancies and inequities which have long existed. The AMA has long been aware of those problems, has examined the problems, and has pointed out the problems. We believe that the time has arrived in which the physician and the patient are treated fairly by governmental programs which promise quality care.

Second, we wish to make clear to the Subcommittee that the AMA has always been, and remains, prepared to work with Congress in developing a fair reimbursement program under Part B. We reiterate that again today.

Nevertheless we must point out that the Subcommittee Notice of these hearings contains a series of "specific issues" which, if enacted according to their tone, would not meet the real issues but would merely compound the problem and only delay the eventual consideration of the real issue of promises versus payment by the Federal government.

In our detailed statement we address those "specific issues" as propounded by the Subcommittee and expand upon our comments there. We believe, nevertheless, that the real solution to the Subcommittee's concern will occur only when Congress is willing to adopt a policy of reimbursing for services rendered at a level more nearly reflective of usual and customary charges. This must be a concomitant element of the Medicare program if it really is to fulfill a promise to provide "medicare beneficiaries access to the same quality of care and affording them the same freedom of choice as others in the community."

Before proceeding further we would briefly like to direct your attention to certain views which appear in the Subcommittee notice announcing these hearings. These views, we fear, may reflect misunderstandings of the present Medicare system.

One view reflected in the language of the Notice says in part, in speaking of the present physician reimbursement mechanism under Medicare: "Since the adoption of this system, however, a number of legislative and regulatory refinements have resulted in situations where the reasonable charge is less adequate in reflecting the actual charges of physicians; increasingly, the charge Medicare allows is less than the actual charge."

It must be recognized that since the enactment of the Medicare law Congress has enacted several important amendments to the law. And while the notice may refer to them as "refinements", no euphumism can disguise their true character—plain reimbursement "curtailments". One result is that a larger responsibility is placed upon the Medicare beneficiary.

The Federal government nonetheless still emphasizes the fact that actual charges can be more than "Medicare-recognized" charges. We must pose the very basic question of how long can Congress "tilt" at a real problem of increasing benefits, increasing the categories of those eligible for coverage and increasing promises to the public while at the same time failing to accept responsibility for correspondingly increased costs?

The other view in the Subcommittee Notice which gives us concern is the statement that, in the view of the Subcommittee, the "refinements" of legislative and regulatory areas pertaining to reimbursement were intended to address inflation "by slowing Medicare recognition of rapid increases in physicians' fees."

We must point out that charges recognized under Medicare have *never* led inflation but instead have followed the inflationary spiral. Moreover, Medicare charges by physicians have, as we have pointed out in our detailed statement, been based upon charge data which at times is up to two years old and have never been based on current data.

These "refinements" have placed the physician in the position of absorbing increased costs today for increasingly expensive equipment, supplies, salaries, office expenses, liability insurance, continuing education, and personal living expenses, and yet being asked to be satisfied with Medicare reimbursement based on yesterday's charges. The result is obvious. It cannot be surprising that the patient must pay more or, as often happens in part, the real differential between actual charges and Medicare recognized charges is shifted to non-Medicare patients.

Mr. Chairman, before Dr. Beddingfield continues the presentation of our summary, I want to take this opportunity to urge you and members of the Subcommittee to review carefully our detailed statement and to consider its recommendations. Those recommendations, we believe, would if adopted by Congress go far in ameliorating presently existing problems of Medicare.

SUMMARY STATEMENT OF EDGAR T. BEDDINGFIELD, JR., M.D.

Mr. Chairman and members of the subcommittee, at this time I would like to highlight the remaining portions of our more detailed statement. Most of my comments—brief because of our desire to conform to the Committee's time limitations—will be directed toward H.R. 13080, which addresses several of the specific "issues" raised by the Subcommittee in its Notice.

H.R. 13080, the Medicare-Medicaid Administrative and Reimbursement Reform Act (introduced in the Senate as S. 3205 by Senator Talmadge) is a massive bill which addresses several issues including physician reimbursement under Medicare.

As to those provisions affecting physician reimbursement under Medicare, we would direct your special attention to Sections 20. 21, and 22 concerning assignments, statewide prevailing charge levels, Medicare index restrictions, and physicians' services under Medicare.

Section 21 of H.R. 13080 would establish a new assignment mechanism under Medicare. It would create two classes of physicians under Medicare: "Participating" physicians and "non-participating" physicians. A participating physician would be one who entered into an agreement with the Secretary in which the physician agreed to accept Medicare reimbursement as payment in full for his services on the basis of an assignment for all his Medicare patients. A non-participating physician would not be eligible to accept assignment with respect to any patient.

Certain entitlements are provided under the bill to induce physicians to sign up as participating physicians. As one inducement the participating physician would be permitted to submit claims on a multiple listing basis (rather than on an individual patient basis) and would be allowed $1.00 as "an administrative cost-saving alowance" for each patient listed. In addition, at least 50 percent of the estimated amount due on each multiple listing claim form would be paid within five days of receipt of the physician's claim (subject to later adjustments).

Mr. Chairman, under the current Medicare program a physician may accept an assignment or bill directly for reimbursement and he may do so on a patient by patient basis. There is no requirement currently that physicians enter into any formal agreement with the Secretary whatsoever. Under the new proposal, however, the physician would have to determine his method of reimbursement and this would apply to all his Medicare patients without exception. There is no justification for the strict limitations contained in the proposal. Moreover, it is indeed ironic that in order to entice physicians into a participating agreement Medicare should have to offer so-called "benefits."

As to the multiple-list billing mechanism, one should assume there would be administrative advantages for Medicare and for the physician. There is no reason, however, why this payment system should not be put into effect immediately under the current billing and payment procedures, if in fact it would operate as an aid in the administration of the program. The provision for early—or more appropriately, timely—payment is certainly no more than physicians are entitled to and should receive at the present time, without the necessity of statutory mandate. Other inducements offered in section 21 are only illusory.

Section 22, in part, also would enact an approach which is intended to "encourage" physician acceptance of assignments for pathology and radiology services—but it does so by penalizing the patients if payment is not made through an assignment.

In passing, it should be observed that in seeking to foster acceptance of assignments H.R. 13080 is itself dichotomous. In one section (sec. 21) it seeks to provide "inducements" for assignments, while in another (sec. 20), as discussed below, it discourages such use through imposition of further discriminatory payment mechanisms.

Under section 20 of H.R. 13080 a new prevailing charge level would be determined for each state which has two or more "localities" within it. For such a state, a statewide prevailing charge level would be determined, and the bill specifically provides that the prevailing charge level shall cover 50 percent (instead of the current 75 percent) of the charges made for similar services in the state. Based on this determination of the statewide prevailing charge level a new limitation is then imposed through operation of the Economic Index. As to the prevailing charge level for a service in a locality, any increase permitted by the Economic Index cannot be applied if, and to the extent that, the resulting prevailing charge level for such service or procedure would exceed the statewide prevailing charge level by more than one-half.

This procedure could, in many cases, result in a diminution in the reimbursable amount which physicians would receive by virtue of future increases provided under current law.

Section 22 of H.R. 13080 would, in part, establish by law a stringent, objectionable definition of "physicians' services" for all physicians and would in addition specifically impose a restrictive definition of anesthesiology and pathology services.

We object strongly to these modifications. All services of physicians as recognized within the geographical area of the physicians' practice should be recognized as "physicians' services" under Medicare. A strict application of the bill language would have dire consequences with respect to proper recognition of, and payment for, all services of physicians under Medicare.

Further provisions of Section 22 relate to those physicians performing pathology or anesthesiology services. Although we recognize that this Subcommittee has announced it does plan to have later hearings pertaining to what it calls "hospital associated physicians" and Medicare reimbursement relating to them, we wish to point out at this time that physicians should not be viewed in special categories for purposes of reimbursement. All are physicians and all should be free to arrange fair reimbursement according to an arrangement which is established by them with other parties.

Congress cannot, and should not attempt to, direct physicians' actions nationwide by statute, and should not enact laws directing what services will constitute physician services. PSROs were given the charge to determine the propriety of medical services and when they meet proper professional standards.

We oppose also the attempt to establish specific statutory limits on physician charges "related to the income or receipts of a hospital". It cannot be assumed that such contractual arrangements necessarily result in excessive fees, nor can it be assumed that equating the physician's "customary charge" with a "reasonable salary" plus additional necessary hospital and physician costs will be an equitable approach.

The foregoing sections of H.R. 13080 should not be considered favorably by the Subcommittee.

I would now briefly like to touch upon the issues of differentials in physician reimbursement and fee schedules. Again, I would urge you to review our detailed statement for a more complete discussion of the issues.

There has been a great deal of discussion recently about differences in reimbursement by Medicare between physicians located in urban areas versus rural areas, as well as differentials in reimbursement made to physicians within various specialties.

We believe that there are valid reasons for differentials among geographic areas as well as among specialties. Medicare itself recognizes that there are differences, as physician reimbursement amounts recognized are to be based upon "localities". These differences have occurred because of differences in the cost of maintaining a medical practice, differences in the cost of living, and even differences in aesthetic values. Some physicians are satisfied to serve in environmentally more pleasant surroundings while receiving less income than they could if they served in other areas. Basically, as to specialties, the reasonableness of a specialist's charge must be judged—as the Medicare law now states—in comparison with the charges of physicians of similar training and experience.

We believe that the Federal goverment should adopt a policy of reimbursing physician services at the usual and customary charges of that physician for his area. Such a policy would recognize that while Federal programs can expect the same quality care as private plans (as now occurs), the Federal government in its programs should assume a comparable obligation for that quality care.

A "fee schedule approach" has been advocated for payment under Medicare and has even been included in some of the presently pending national health insurance bills. However those proposals which would impose such a system, including H.R. 6699 pending before you, are unwise and should not be adopted. They contemplate a mechanism establishing throughout an area schedules which would limit the total medical health care expenditures. Although everyone desires to reduce costs wherever possible, a lowering of costs cannot be justified when patient care would be jeopardized. If fee schedules were introduced, we believe that any reduction in costs would result in further discouraging physician participation and limiting availability of care by reducing patient access to a physician of his choice. Unrealistic limits will affect quality and availability. Such a result would undermine quality patient care in the Medicare program.

Mr. Chairman, we again invite consideration of our full statement. At this time we will be pleased to respond to any questions which the Subcommittee may have.

STATEMENT OF RAYMOND T. HOLDEN, M.D.

Mr. Chairman and members of the subcommittee, I am Raymond T. Holden, M.D., a practicing physician in Washington, D.C. I am Chairman of the Board of Trustees of the American Medical Association and am pleased to present on behalf of the Association its views on the important subject with which your Subcommittee is today concerned. With me making the AMA presentation is Edgar T. Beddingfield, Jr., M.D., who is in medical practice in Wilson, North Carolina. Dr. Beddingfield is Chairman of the AMA Council on Legislation. Accompanying us is Harry N. Peterson, Director of our Department of Legislation.

At the outset, Mr. Chairman, we want to express on behalf of all physicians, appreciation for this timely review of physician reimbursement policies under Medicare. The profession is keenly aware of the overall desire of this Subcommittee to fulfill its responsibility in seeing that federal Medicare obligations in providing health care for the elderly are full and properly discharged. This hearing, centering on one aspect, is just one of a series apparently intending to review many major aspects of the program.

After a decade of operation, it is indeed most appropriate that the Medicare program receive careful analysis, not only from the fiscal viewpoint of government, but from the viewpoint of satisfaction and reasonable expectation of beneficiaries of the program. The two interests, which will clearly come into focus during these hearings—i.e., the government's interest in fiscal restraint and its interest in providing beneficiary satisfaction with the program—will surely emphasize the magnitude of the undertaking and may well prove irreconcilable. Caught in the middle of these divergent interests are the physicians and other providers of health services. Since enactment of the program, a major emphasis of the Congress has been on cost containment. This has been an inevitable reaction, since the program has year after year far exceeded cost expectations. That the program costs exceed early estimates, however comes as no no surprise. It is axiomatic that any program promising readily acceessible, highest quality health care, incorporating all the newest technology, will be expensive. It is therefore the magnitude of the overage which causes the grave concern.

Mr. Chairman, the medical profession is especially concerned, too, for the physician is the primary person having a personal face-to-face relationship with the beneficiary. To the patient, "Medicare" itself is an impersonal faceless bureaucracy answerable for its inadequacies only through the postal service. Members of the profession, on the other hand, become in reality the visible image of Medicare, and they have increasingly become answerable for deficiencies in Medicare.

The profession welcomes this oversight series of hearings, just as it did the recent hearings held to investigate the general administration of the program through the promulgation of regulations. Prompting those hearings, and substantiated by testimony, was the great base of dissatisfaction extant among all major classes of providers. This dissatisfaction stemmed not only from regulatory abuse but from a foundation in a great variety of legislative controls, notably those imposed by P.L. 92–603, the Social Security Amendments of 1972.

I. The Subcommittee Notice

Upon reviewing the Subcommittee notice of these hearings, we note that the Subcommittee has expressed its concern that the present Medicare reimbursement system has failed to respond adequately to what the Subcommittee perceives as the "primary objectives" in determining reimbursement amounts for physicians' services under the Medicare program.

The "primary objectives" as pointed out by the Subcommittee include "adequate financial protection" for program beneficiaries, "rational payment patterns" for services of physicians, and avoidance of "inflationary tendencies."

We too are concerned with these, and other, objectives in the Medicare reimbursement program. Our primary concern, however, is that the reimbursement system be established in such a manner as to assure that the highest level of quality care for Medicare beneficiaries will be provided with the least amount of governmental interference. Unnecessary limitations and restrictions must be avoided. However, those disagreeable impositions do occur in today's reimbursement mechanism.

As you review the important question of Part B reimbursement under Medicare we would urge that you consider our thoughts as expressed here today and that you clearly understand that we too are deeply concerned by the issues which are raised. In fact we have often expressed our views as to the problems inherent in the present Medicare reimbursement program. Positive changes need to be made. Nevertheless, we would also urge you not to base changes upon assumptions which may in fact be inaccurate or incomplete.

It is imperative that changes that are needed be made in a manner which will further the "primary objectives" as stated by this Subcommittee and not further exacerbate existing problems which have developed because of inappropriate statutory provisions and administration of the Medicare program. We would also urge that changes not be hastily enacted but that this Subcommittee explore fully not only the benefits but also any detrimental implications of any proposed changes.

During your hearings you may hear conflicting suggestions as to the appropriate changes which should be made. However, we would urge you to consider our suggestions. Mr. Chairman and members of the Subcommittee, in the light of two essential aspects.

First, our views are based upon critical examination over a long period of time. The problems which are presently manifested in Part B payments under Medicare are not new but have been occurring for several years. Only recently has full attention been directed toward the inherent discrepancies and inequities which have long existed. The AMA has long been aware of those problems, has examined the problems, and has pointed out the problems. We believe that the time has arrived in which the physician and the patient should be treated fairly by governmental programs which promise quality care. Although quality care has continued to be furnished by physicians, the government has not responded reciprocally with the level of reimbursement commensurate with its promises to beneficiaries and providers.

Second, we wish to make clear to the Subcommittee that the AMA has always been, and remains, prepared to work with Congress in developing a fair reimbursement program under Part B. We reiterate that again today.

As we continue our statement we will point out additional areas of concern. Before proceeding further, however, we would briefly like to direct your attention to certain views which appear in the Subcommittee notice announcing these hearings. Our purpose in directing attention to those views is to identify a proper common understanding as to the background of the present problems in Medicare reimbursement.

Of these views, two in particular deserve special comment. It is first stated that "the reasonable charge system adopted by the original medicare law was similar to some physician reimbursement approaches then in use". The Medicare law as passed provided payment for physicians' services on the basis of 80 percent of the "Medicare determined" reasonable charge (above the annual deductible). The Secretary of HEW was to enter into contracts with carriers to administer Part B of the program and, among other things, to make determinations of the rates and amounts of payments to be made pursuant to Part B requirements.

Thus the clear intent of Congress upon enacting Medicare was to provide medical benefits to participants to be reimbursed at 80 percent of the reasonable charge, and the reasonable charge was intended to reflect contemporary facts. In fact the original Medicare Act stated that the carrier was to assure that "where payment . . . is on a charge basis . . . such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier . . ." It appears to us that this language reflected an intent to make Medicare recognized reasonable charges comparable with those recognized in privately insured programs. As the Subcommittee notice further states: "One reason this system was thought to be desirable was that it reflected both the customary charges of an individual physician and the charges of physicians generally in the community—thus allowing medicare beneficiaries access to the same quality of care and affording them the same freedom of choice as others in the community. Since the adoption of this system, however, a number of legislative and regulatory refinements have resulted in situations where the reasonable charge is less adequate in reflecting the actual charges of physicians; increasingly, the charge medicare allows is less than the actual charge."

There can be little wonder about the reasons for the concluding portion of the above statement. It must be recognized that since the enactment of the Medicare law the beneficiary pays a larger portion because the Congress has enacted several important amendments to the law. And while the notice may refer to them as "refinements", no euphuism can disguise their true character—plain reimbursement "curtailments".

In succeeding years Congress added restrictive provisions to the Medicare law. Moreover the regulatory agency for Medicare issued regulations restricting the amount of reimbursement first by setting reasonable charge at approximately the 90th percentile of all charges, reducing it later to the 83rd percentile, and then to the 75th percentile. In addition, data for establishing charges was never current. In 1972, statutory amendments pushed this base back to almost two years. In addition, there have also been imposed "economic index" restrictions which arbitrarily limit increases and use as a base the 1973 prevailing charge levels (themselves based on 1971 data).

The Federal government nonetheless still emphasizes the fact that actual charges can be more than "Medicare-recognized" charges. This apparent puzzlement cannot longer be masked.

We must pose the very basic question of how long can Congress "tilt" at a real problem of increasing benefits, increasing the categories of those eligible for coverage and increasing promises to the public while at the same time failing to accept responsibility for correspondingly increased costs? Will Congress continue to shift program costs to beneficiaries, by limiting reimbursement to those levels it deems to be reasonable, while at the same time expressing puzzlement at a sharply sagging assignment rate? How can unrealistic "recognized" reasonable charges continue to be based on data two years old and on data not truly reflecting the costs of current practice? How can inflation in the costs of doing business be controlled through limiting "recognized" charges based on indices, percentiles, and amounts which were arbitrary when imposed and which, even if they were not arbitrary, are based on outdated data? Given the demonstrable chasm between usual, customary and reasonable charges (reflecting charges in the real world) and the amount recognized for the Medicare-defined "reasonable charge", what kind of fairness could be expected in a system of pre-payment, fee-schedule, mandatory assignment, or any other form of program-imposed "recognized" charges? Until such time that the Congress is willing to match its promises with adequate funding, the "crisis" in Medicare reimbursement will continue. Furthermore, dissatisfaction and disparity will continue until such time as Congress is willing to commit itself to providing proper payment for quality service.

The other view in the Subcommittee Notice which gives us concern is the statement that, in the view of the Subcommittee, the "refinements" of legislative and regulatory areas pertaining to reimbursement were intended to address inflation "by slowing medicare recognition of rapid increases in physicians' fees."

We must point out that charges recognized under Medicare have *never* led inflation but instead have followed the inflationary spiral. Moreover, such changes by physicians have, as we pointed out earlier, been based upon charge data which at times are up to two years old and have never been based on current data. This unfair situation enables Medicare programs to recognize increases at a substantially lower level than current inflationary rates. This is further restrained by the 75th percentile which itself is restricted in its application by the recently imposed economic index. These "refinements" have placed the physician in the position of absorbing increased costs today for increasingly expensive equipment, supplies, salaries, office expenses, liability insurance, continuing education, and personal living expenses, and yet being asked to be satisfied with Medicare reimbursement based on yesterday's charges. The result is obvious. It cannot be surprising that the patient must pay more or, as often happens in part, the real differential between actual charges and Medicare-recognized charges is shifted to non-Medicare patients. The result is unfortunate, especially considering the promises perceived by the Medicare population as having been made to them; but in the real world the physician finds himself in a position of having to pay for today's costs at today's prices.

Nevertheless, the Subcommittee Notice contains a series of "specific issues" which, if enacted according to their tone, would not meet the real issues but merely compound the problem and only delay the eventual consideration of the real issue of promises versus payment by the Federal government.

In our statement we will address those "specific issues" as propounded by the Subcommittee and will expand upon our comments above. We believe, however, that the real solution to the Subcommittee's concern will occur only when Congress is willing to adopt a policy of reimbursing for services rendered at a level more nearly reflective of usual, customary, and reasonable charges. This must be a concomitant element of the Medicare program if it really is to fulfill a promise to provide "medicare beneficiaries access to the same quality of care and affording them the same freedom of choice as others in the community."

Mr. Chairman, Doctor Beddingfield will continue our statement at this time.

STATEMENT OF EDGAR T. BEDDINGFIELD, JR., M.D.

Mr. Chairman and Members of the subcommittee, the subcommittee states in its notice one approach for consideration in revision of Medicare reimbursement of physicians is found in H.R. 13080, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

That bill (introduced in the Senate as S. 3205 by Senator Talmadge) is a massive bill which addresses not only physician reimbursement under Medicare but also addresses Medicaid reimbursement, hospital reimbursement, payment for services of hospital associated physicians, administrative changes in Medicare and Medicaid and a variety of other issues.

For purposes of our present testimony, we would like to address ourselves to H.R. 13080 as it is applicable to physician reimbursement under Medicare in relation to the various issues raised in the Subcommittee notice. Furthermore, since the Subcommittee has indicated that later hearings will be held as to Medicare reimbursement of hospital associated physicians, we will reserve our comments on H.R. 13080 as to that issue for a later date.

II. H.R. 13080—The Medicare-Medicaid Administrative and Reimbursement Reform Act

A. ASSIGNMENTS UNDER MEDICARE (SECTIONS 21, 22)

Section 21 of H.R. 13080 would establish a new assignment mechanism under Medicare. It would create two classes of physicians under Medicare: "Participating" physicians and "non-participating" physicians. A participating physician would be one who entered into an agreement with the Secretary in which the physician agreed to accept Medicare reimbursement as payment in full for his services on the basis of an assignment for all his Medicare patients. A non-participating physician would not be eligible to accept assignment with respect to any patient.

Certain entitlements are provided under the bill to induce physicians to sign up as participating physicians. As one inducement the participating physician would be permitted to submit claims on a multiple listing basis (rather than an individual patient basis) and would be allowed $1.00 as "an administrative cost-saving allowance" for each patient listed. In addition, at least 50 percent of the estimated amount due on each multiple listing claim form would be paid within five days of receipt of the physician's claim (subject to later adjustments).

It is specifically provided that no "cost saving allowance" would be payable for physician services performed in a hospital (whether on an inpatient or outpatient basis) unless the physician ordinarily bills directly and (1) such services were in the form of surgical procedures or anesthesiological services, or (2) such services were performed by a physician whose office or regular place of practice was at a locality other than the hospital.

Nor would any such cost saving allowance be allowed on account of services consisting solely of laboratory or X-ray services performed outside the office of the physician claiming payment therefor.

Mr. Chairman, the provisions of section 21 revising the assignment procedures would vitiate fundamental principles of payment for physician services upon which the Medicare program has been premised since its beginning. A physician may now accept an assignment or bill directly for reimbursement and he may do so on a patient by patient basis. There is no requirement currently that physicians enter into any formal agreement with the Secretary whatsoever. Under the new proposal, however, the physician would have to determine his method of reimbursement and this would apply to all his Medicare patients without exception. It undoubtedly will be argued by some that the course to be undertaken is still optional with the physician; however, there is no justification for the strict limitations contained in the proposal. Moreover, it is indeed ironic that in order to entice physicians into a participating agreement Medicare should have to offer so-called "benefits."

As to the multiple list billing mechanism, one should assume there would be administrative advantages for Medicare and for the physician. There is no reason, however, why this payment system should not be put into effect immediately under the current billing and payment procedures if in fact it would operate as an aid in the administration of the program. The one dollar per listing inducement will have little persuasive effect when measured against any losses from eliminating the present direct billing option. The provision for early—or more appropriately, timely—payment is certainly no more than physicians are entitled to and should receive at the present time, without the necessity of statutory mandate. Indeed, if it would be within the capability of Medicare to achieve the timely payment procedures projected under the bill, the same energies ought to be channeled today into achieving that same goal. It would be disheartening if convenient administrative aids are now available—but are not being utilized.

The approaches to assignments, as found in section 21, should be rejected as being discriminatory and unwise.

In reviewing H.R. 13080 as it relates to assignments another section should be discussed. Section 22, in part, would enact an approach which is also intended to "encourage" physician acceptance of assignments—but it does so by penalizing the patients if payment is not made through an assignment. Under present law, pathology and radiology services to hospital inpatients are paid from Part B at 100 percent of the "reasonable charge", whether the physician has accepted assignment or not. H.R. 13080 would change the amount of such Medicare payments to the usual 80 percent of the "reasonable charge", but only when the physician does not accept assignment, and it would then permit crediting of the patient's 20 percent of the "reasonable charge" towards the annual Part B deductible. We point out that the Medicare "reasonable charge" for pathology and radiology services remains the same, whether or not the physician accepts assignment.

The Association questioned prior to the time the 100 percent payment was allowed in P.L. 90–248 whether the coinsurance factor should be eliminated for specific segments of medical care. We question even more strongly now the establishment of different rates of payments by Medicare for services provided on assignment and for the same services when billed to the patient. We believe that this approach violates basic principles of equity to all Medicare beneficiaries, since all pay the same out-of-pocket premium but some would receive different degrees of coverage as a result of factors over which they have little or no control.

Mr. Chairman, it is obvious that the goal sought to be accomplished by section 21 and the above discussed portion of section 22 is to achieve an increase in the assignment use rate.

The fact that inducements are necessary in order to buttress a sagging assignment rate should cause an examination of basic factors involved. Without question the current system, with its insufficient reimbursement rate, is the major deterrent to assignments. Earlier in our statement we covered in some detail the many inhibiting factors involved. The artificial and discriminatory payment mechanism under Medicare has caused an increasing rejection of the assignment method for receiving payment. The 75th percentile formula, based on old and unrealistic data (at times almost two years old) and further curtailed through application of the Economic Index, has caused the great disenchantment of many physicians with the assignment method.

In passing, it should be observed also that in seeking to foster acceptance of assignments H.R. 13080 is itself dichotomous. In one section (sec. 21) it seeks to provide "inducements" for assignments, while in another (sec. 20) it discourages such use through imposition of further discriminatory payment mechanisms.

Rather than seek to initiate new devices to bolster the current assignment levels based on a perpetuation of artificial and arbitrary payment levels, it is time to examine and to make realistic the basic Medicare reimbursement formula and payment mechanisms. If indeed it is the intent of Congress to achieve more widespread acceptance of assignments, this would be better accomplished by making the reimbursement level under that system more acceptable and in accord with usual and customary practices. Medicare limitations, as through application of the Economic Index, are discriminatorily imposed, and should be removed.

Legislative proposals which would seek to "solve" a Congressional concern by imposing additional disincentives to accepting assignments under Medicare are not the answer.

We urge strongly that the above provisions of sections 21 and 22 of H.R. 13080 relating to assignments should not be adopted.

B. STATEWIDE PREVAILING CHARGE LEVEL, AND MEDICARE INDEX RESTRICTION (SECTION 20)

Section 20 of H.R. 13080 would significantly change determinations of reasonable charges under Medicare. At the present time prevailing charge levels are statutorily defined in localities as including 75 percent of the customary charges made for similar services in that locality, subject only to "economic index" allowable increases. Those index limitations are imposed so that the charge level for any fiscal year beginning after June 30, 1973 would not exceed the level determined during the fiscal year ended on that date, except to the extent that a higher level is justified by economic changes determined to be acceptable by the Secretary on the basis of appropriate economic index data.

Under H.R. 13080, however, a new prevailing charge level would be determined for each state which has two or more "localities" within it. For such a state, a statewide prevailing charge level shall be determined, and the bill specifically provides that the prevailing charge level shall cover 50 percent instead of the current 75 percent) of the charges made for similar services in the state. Based on this determination of the statewide prevailing charge level, a new limitation is then imposed through operation of the Economic

Index. As to the prevailing charge level for a service in a locality, any increase permitted by the Economic Index cannot be applied if, and to the extent that, the resulting prevailing charge level for such service or procedure would exceed the statewide prevailing charge level by more than one-half.

This procedure could, in many cases, result in a diminution in the reimbursable amount which physicians would receive by virtue of future increases provided under current law. In no case however would section 20 provide to any physician more than the increases which the current law would allow. It appears that the real effect of the new methodology would be to cause a leveling of reimbursement payments. This leveling would be accomplished, however, through a reduction (particularly in metropolitan areas) of any increases which otherwise generally would be due under the economic index and to which physicians currently would be entitled under Medicare. While the reimbursement levels in non-urban areas might for a period of time undergo normal increases which could be higher (at least percentagewise) than those to be recognized in metropolitan areas under the Economic Index, this stifling of proper fee recognition for all physicians would be detrimental to maintaining a proper level of care under the program.

Discrimination in the application of the economic index in states with two or more localities would also result. Some physicians would receive the full amount allowed by the index, others would not. Further discrimination would result because the index would apply fully to all physicians in states constituting a single locality. The artificial ceiling imposed on Medicare reimbursements under section 20 of H.R. 13080 could affect participation by physicians and affect the availability of care for Medicare patients. This type of limitation would also further aggravate the shifting of expenses under Medicare and Medicaid to private patients.

In our opinion reimbursement levels imposed upon physicians are currently substandard by virtue of existing controls. Section 20 imposing a new statewide prevailing charge level should not be adopted.

C. ECONOMIC INDEX

We are concerned over any view of Medicare reimbursement reform that contemplates more limitations and restrictions are needed.

As an example of the result of Congressionally perceived need for restrictions on physician reimbursement we would like to relate to you the features of Section 224(a) imposed by P.L. 92–603 and also implementation of that section.

Section 224(a), in relevant portion, amended section 1842(b)(3) of the Social Security Act, by adding the following: No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any fiscal year beginning after June 30, 1973, may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes.

As can be seen, the crux of the statute is premised upon the requirement that, beginning in fiscal year 1974, increases in the prevailing charge level would be limited by an economic index established by the Secretary.

It was not until April 14, 1975, almost two years after enactment of P.L. 92–603, that implementing regulations were promulgated.

The language of the proposed regulations (section 405.504) was largely a restatement of the then current regulation, augmented by additional language from the statute. In fact, section 224(a) itself contained considerable language which existed in the regulations at the time of enactment of P.L. 92–603.

An explanation of what components would comprise the index, and how the index would operate, were totally lacking in the regulations. An example was given in the proposed regulations, illustrating relative weights which might be attributed to the office-expense and the earnings components. Then followed, in the example, calculations based upon hypothetical factors of only depictive, methodological value indicating how a cumulative economic index based on subindices might be ascertained.

The "example" to which the proposed regulations referred was itself taken from the House Report accompanying Sec. 224 of P.L. 92–603, and was also used in the Senate Report. In both these reports the formula (as used in the proposed regulations) was specifically referred to as an example of how an index might operate. We were appalled to see that the example was seriously advocated as the formula, and that the advocacy of such a formula was attempted by means of an innocuous "example" in the proposed regulations. On the other hand, we anticipated and expected a proposal for an index to be a clear, concise, and definitive explanation of a method so that appropriate consideration of the proposal could be made. The Senate Report contemplated that "both initially and over the long run, the most refined indexes that can be developed" would be used by the Secretary.

The regulations were void of any economic index data upon which meaningful comment could be provided.

In the introductory discourse preceding the formal language of the proposed regulation, it was stated that the proposed amendments provided that any recognition of a prevailing charge increase for a physician's services in a locality would be limited by an "appropriate national economic index" so that Medicare reimbursement would not recognize without limitations whatever increase in charges was established in a locality. Continuing, it was stated: "Recognition of charge increases would be limited to rates that economic data indicate would be fair to all concerned and follow, rather than lead, any inflationary trends."

The statement that increases were to be "fair to all concerned and follow, rather than lead, any inflationary trends", is, on its face, contradictory, and, when considered in the context of the history of restrictions and limitations placed upon Medicare fees, was an affront to the physicians who had cooperated throughout a long period during which there had been imposition of arbitrary freezes and targeted economic controls. The two-year time lag involved in the recognition of physician fees was in itself unique and operated in such a way that Medicare fee recognition long lagged behind current trends in physician's fees.

It is our opinion that the regulations imposing economic controls on one sector of our economy were, and remain, invalid and discriminatory. Their invidiousness is intensified when consideration is given to the fact that the controls and limits on the government financial contribution towards payment of the medical care of a Medicare beneficiary set arbitrary limits on prevailing charges, and thus shift an increasing burden onto the Medicare beneficiary. Such arbitrary limitations could further discourage the use of assignments.

Yet the proposed regulations were finalized very much as proposed.

The actual components of the economic index, an issue of intense interest to the medical profession, were never published as proposed regulations but rather in the form of a notice in the Federal Register. That notice maintained those items in the relative weight as assigned by HEW as in the view of HEW were appropriate.

The immediate result of a two-year delay in imposing regulations was in many cases a reduction in Medicare-recognized reasonable charge. A physician accepting assignment could receive less for a procedure performed on July 1, 1975 than he received for the very same procedure performed on June 30, 1975 although charging identical amounts. Conversely, a patient could be paying more on July 1, 1975 than on June 30, 1975 for the same procedure although the charge was the same in either case.

Congress, ascertaining this illogical result, reacted to devise a solution through enactment of P.L. 94–182. However, instead of recognizing the concept of more nearly tying reimbursement to reasonable charges by eliminating the economic index, Congress mandated that no recognized Medicare charge for fiscal 1976 could be less than that recognized at the end of fiscal 1975. Even this solution, though, only delayed a possible "roll-back" until fiscal 1977.

With a problem once more being pointed out to it, Congress again responded by enacting additional legislation, P.L. 94–368. Although this enactment prevents any future "roll-back" in prevailing charges to less than those recognized on June 30, 1975, it again fails to provide a solution to the presently artificial and unfair reimbursement amounts recognized under Medicare. P.L. 94–368, by prohibiting any recognition of Medicare fees for any year at a rate lower than that recognized as of June 30, 1975, will only ameliorate the extremes of an otherwise arbitrary method of recognizing reasonable charges.

And yet, irrespective of the present unsuccessful system which seemingly systematically alienates physicians, over promises (and then dissatisfies) beneficiaries, and shifts increasingly its costs to private patients, Congress is presently considering legislation which could further exacerbate those conditions.

Section 20 of H.R. 13080 would materially further reduce even this standard and would even limit the application of the Economic Index by superimposing a new statewide prevailing charge limitation. Such a restriction would adversely affect Medicare patients. We recommend that provisions as reflected by Section 20 of H.R. 13080 not be adopted.

We note that one provision in that same section 20 is intended to permit greater flexibility in recognition of charges in shortage areas under special circumstances.

The intent of this provision is salutary. Its objective is to induce physicians to enter shortage areas to establish medical practice. However, the methodology set out and the effects of permitted variations must be examined very carefully. The allowance for a physician to enter a shortage area and establish Medicare reimbursement levels higher than those currently recognized under the Medicare program in such circumstances may in fact cause inequities in reimbursement recognition in that area. As we understand the provision, it would be possible for a physician establishing a practice in a shortage area to establish fee reimbursement levels at charges higher than some physicians who already may be in practice in that same area. This type of disparity could cause undesirable results. This could occur particularly if physicians who had established practices in the shortage area were required to perform services at rates which are less than those charged by new physicians coming into the area. The potential effects of such a change (as proposed under Section 20 of H.R. 13080) should be analyzed very carefully.

D. PHYSICIANS' SERVICES UNDER MEDICARE—AS MODIFIED BY H.R. 13080

Section 22 of H.R. 13080 would, in part, establish by law a stringent definition of "physicians' services" and would define anesthesiology and pathology services.

Medicare law now defines "physicians' services" in general terms as "professional services performed by physicians", HR. 13080 would specifically exclude from that definition those services the physician performs as an educator, an executive, or a researcher and would exclude even patient care services unless "personally performed by or personally directed by a physician" for the benefit of the patient and unless the service is of such a nature that its performance "by a physician is customary and appropriate."

Although this amendment is carried in the bill under the heading "Hospital-Associated Physicians" the amendment is not so limited, and the placement of this amendment under that heading is misleading. In fact this amends the general definition of "Physicians' Services" in section 1861(q) and consequently the new limitations created would apply to all "physicians' services" throughout the Medicare law and program. Consequently we object strongly to this modification. All services of physicians as recognized within the geographical area of the physicians' practice should be recognized as "physicians' services" under Medicare. A strict application of the bill language would have dire consequences with respect to proper recognition of, and payment for, all services of physicians under Medicare.

Even if the provisions were intended to affect only the inpatient services of "hospital-associated physicians" and it were so stated, the modification would be nonetheless objectionable.

The writers of regulations, armed with the proposed statutory language which includes as "physicians' services" only patient care service which is "personally performed" or "personally directed" and "of such a nature that its performance by a physician is customary and appropriate", could arbitrarily change the practice of medicine as fully recognized in communities today. For example, would Medicare now refuse a physician's claim because the service is provided by a nurse or a physician's assistant?

Whatever its intent, a legal definition which states that a physician acts as a physician only when directly treating a patient and when performing services only a physician can perform can only lead directly to confusion in the Medicare program and further dismemberment of health care.

Furthermore, the physician as educator, researcher, or administrator does not cease to be a physician; indeed, since the earliest days of the medical profession, teaching and research have been recognized as intrinsic parts of the practice of medicine, and, as medicine has become more organized and technologically sophisticated, administrative tasks have developed which can be performed most effectively only by a practicing physician.

We protest strongly any artificial division of the physician's role.

Further provisions of Section 22 relate to those physicians performing pathology or anesthesiology services. Although we recognize that this Subcommittee has announced that it does plan to have later hearings pertaining to what it calls "hospital associated physicians" and Medicare reimbursement relating to them, we wish to point out at this time that physicians should not be viewed in special categories for purposes of reimbursement. All are physicians and all should be free to arrange fair reimbursement according to an arrangement which is established by them with another party.

We would therefore at this time like to direct our comments to those provisions of section 22 which attempt to impose limitations upon certain physicians.

We protest the attempt to define precisely what are "personally performed" or "personally directed" services in the fields of anesthesiology and pathology. Medicine is a living science, which changes from year to year—sometimes from day to day—while laws may take years to change. Even the regulatory process, as this Congress is well aware, can be dilatory and insufficiently flexible. The language of this section goes further in limiting medical practice than the laws under which physicians are licensed to practice. Its restrictions on anesthesiology and pathology are not only unwise legislation in themselves, but tend to undermine the very legislation passed by this Congress in 1972 intended to improve care under Medicare, Medicaid, and Maternal and Child Health programs. Congress has established PSROs to determine whether patients under the three programs are receiving care which meets appropriate professional standards of quality.

This bill would superimpose on PSRO deliberations specified standards as to how many patients a physician could personally treat or personally direct treatment for and still have the treatment considered a "physicians' service". It would say which services of pathologists are "physicians' services" and which are not.

Congress cannot, and should not attempt to, direct physicians' actions nationwide by statute, and should not enact laws directing what services will be recognized as physicians' services. PSROs were given the charge to determine the propriety of medical services and when they met proper professional standards.

We would suggest that this Committee consider very carefully the limitations this bill would set on care recognized as properly provided by anesthesiologists. It would state, for purposes of the program, that an anesthesiologist can "personally perform" physicians' services for only two patients at a time, and can only "personally direct" care for four patients at a time, and that the "reasonable charge" for "personally directed" care will be half that for "personally performed" care.

By this standard, an anesthesiologist will receive the same payment for two patients for whom he provides all the listed services as for four patients for whom he provides all but one of the listed services, and for whose care he remains legally liable. This change will probably result in a reduction in the anesthesiology services available to Medicare, Medicaid, and Title V patients.

The Congress should not set in inflexible statutory provisions what elements will be required to constitute acceptable performance of practice by anesthesiologists or pathologists.

We oppose also the attempt to establish specific statutory limits on physician charges "related to the income or receipts of a hospital". It cannot be assumed that such contractual arrangements necessarily result in excessive fees, nor can it be assumed that equating the physician's "customary charge" with a "reasonable salary" plus additional necessary hospital and physician costs will be an equitable approach. It should be recognized that such contractual arrangements involve some element of financial risk for the physicians involved, which a salaried arrangement obviates. For the same reasons we object to limitations on arrangements with hospitals or medical schools whereby payment for physician services is limited to a salary equivalent.

Section 22 of H.R. 13080 should not be considered favorably by the Subcommittee.

III. Differentials in Physician Reimbursement

There has been a great deal of discussion recently about differences in reimbursement by Medicare between physicians located in urban areas versus rural areas, as well as differentials in reimbursement made to physicians within various specialties.

On one hand people have spoken of these differentials, which Medicare presently may recognize, with the concern that reasonable charges recognized by Medicare are higher in urban areas than in rural areas and that they differ between "primary care" physicians as opposed to other physicians. Yet, on the other hand, advocates of differentials in reimbursement have suggested that there be differences in Medicare-recognized fees, with higher fees recognized in rural areas and with physicians receiving the same reimbursement amount for the same services performed. Such differentials are advocated as necessary to induce physicians into shortage areas and to induce more physicians to practice what they call "primary care".

We believe that there are reasons for differentials among geographic areas as well as among specialties. Medicare itself recognizes that there are differences, as physician reimbursement amounts recognized are based upon "areas". These differences have occurred because of differences in the cost of maintaining a medical practice, differences in the cost of living, and even differences in aesthetic values. Some physicians are satisfied to serve in environmentally more pleasant surroundings while receiving less income than they could receive if they served in other areas. Basically, as to specialties, the reasonableness of a specialist's charges must be judged—as the Medicare law now states—in comparison with the charges of physicians of similar training and experience, not in comparison with other specialties. We believe that the statement as found in the Committee Notice stating that there are differences between what "primary care physicians" and other physicians charge as recognized by Medicare perhaps reflects some misunderstanding of all the medical specialties. It may not perhaps be generally understood, but today almost all physicians (over 85 percent) are specialists. Physicians engaged in family practice, or in pediatrics, or in surgery, are, in fact, also specialists. Family practice physicians, certainly directly associated with primary care, are specialists and are required to take extended graduate studies and training in their specialty just as is any other specialist.

We are concerned further about the indication in a statement of the Notice which would appear to split physicians into "primary care physicians" and other physicians. It must be understood that a "primary care" specialty is not, as such, an identifiable specialty. "Primary care" is sometimes used to include pediatrics, family practice, OB-GYN, and internal medicine, to the exclusion of other physicians. However, physicians in every specialty serve as "primary care physicians". A physician of any specialty can be the one who first sees the patient, who makes the diagnosis and who treats or who may refer the patient to another physician, either in the same or a different specialty. On the other hand, there are physicians in those groups which some often refer to as "primary care" who are in fact physicians to whom patients are referred and who may never initiate a primary contact with patients. It is, therefore, inaccurate to view some physicians as "primary" versus others with the implication that only "primary" physicians are initial patient contact physicians. Reimbursement should not be based upon this type of artificial differential.

There is also a question raised by the Notice which suggests that reasonable charges as presently recognized by Medicare affects the specialty and geographical distribution of physicians. Apparently it is thought that any variations that may occur among these areas have implications for the number of physicians choosing to practice in these areas. We believe there is little firm evidence that physicians base their choice of location on differences of payment. For example, in the recently issued study by the Institute of Medicine entitled "Medicare-Medicaid Reimbursement Policies", findings are made that directly question the contention that variations in Medicare-recognized reimbursement rates play an important role in selecting either a specialty into which a physician enters or in selection of the geographical area in which he may practice. On the contrary, as to influence upon a physician in choosing a location, the study specifically points out that "although economic variables do not seem to be important in explaining the current distribution of physicians, certain non-economic variables appear to be very influential".

As to choice of specialty training, the study also points out that "economic factors alone, particularly expected lifetime earnings, do not provide an adequate explanation". The study, in addition, goes on to point out that "physician specialty preference is conditioned by background and personality characteristics and is reinforced by medical school and graduate medical education experiences". The findings of that study clearly point out that specialty and geographic location choices are affected by many factors and that financial incentives play only a minor role in those determinations. We believe that the findings referred to are quite accurate ad reflect what the AMA has pointed out in the past, that specialty choice and location choice are not based upon what federal programs pay in terms of reimbursement but rather are based upon a wide range of factors.

Perhaps of greater significance in seeking to affect a choice of location or specialty is the following statement in the study: "In order not to discourage primary care physicians from accepting Medicare and Medicaid beneficiaries, the allowed charges for these programs should be comparable to those of other third party payors". We believe that this is a highly significant recommendation, not only as it relates to practice incentives, but also as it would apply to use of assignments. In reflecting the low recognition of charges by Medicare in relation to the more realistic payments of other third party payors, the study also points out that "the utility of Medicare and Medicaid physician payment policies to achieve these [geographic distribution] changes is limited". The Federal government should adopt a policy of reimbursing physician services in the usual, customary, and reasonable charge of that physician for his area. Such a policy would recognize that while Federal programs can expect the same quality care as private plans (as now occurs), the Federal government in its programs should pay a comparable share for that quality care.

IV. Fee Schedules—H.R. 6699

Another of the "specific issues" enunciated by the Subcommittee pertains to establishment of fee schedules under Medicare.

Fee schedules have been advocated by some as a certain means of assuring that fees will not increase while also assuring quality medical care. According to the argument, fee schedules would allow the government to ascertain more accurately in advance what its total expenditures will be for the next year, thus allowing Medicare to "budget" health care. In addition, the argument continues, only those physicians will participate in the program who are willing to accept the fee as scheduled.

A "fee schedule approach" has been advocated for payment under Medicare and has even been included in some of the presently pending national health insurance bills. However those proposals which would impose such a system are unwise. They contemplate a mechanism establishing throughout an area schedules which would limit the total medical health care expenditures. Although everyone desires to reduce costs wherever possible, a lowering if costs cannot be justified when patient care would be jeopardized. If fee schedules were introduced, we believe that costs would be reduced only by further discouraging physician participation (and thus reducing patient access to a physician of his choice) or by setting limits so unrealistic in relation to the value of the services performed that Medicare recipients could not receive extensive quality care.

The creation of fee schedules which fail to recognize true charges would result in a continued decrease in the assignment rate, an increased dissatisfaction by physicians and patients, and an enhanced public disenchantment in governmental health programs.

We believe that this type of approach under a federal limit on total health care with emphasis upon a mechanism of feed schedules could in fact undermine quality patient care. This detrimental condition would occur through a federal desire to provide broad medical care to beneficiaries, to demand the highest quality, and to reimburse at artificially and unrealistically created levels. Such a system could only result in patient dissatisfaction since cost, availability, and quality are irrevocably intertwined. One cannot be arbitrarily restricted without affecting the other two.

As an example of one type of legislative proposal for fee schedules, there is presently pending before your Committee H.R. 6699. That bill would amend the Social Security Act by adding provisions allowing the Governor of a state to request the Secretary of HEW to reimburse physicians' services under Medicare and Medicaid on a fee schedule applicable to that state.

In determining a fee schedule, the Governor, in consultation and with recommendations of the state medical societies, would prepare a schedule which would be accepted by the Secretary of HEW for Medicare and Medicaid, provided that Federal costs for such services for the calendar year preceding the effective date of a schedule would have been no higher had such a schedule been in effect. Fee schedules for subsequent years would be determined in the same manner as the original schedule, restricting increases so as not to exceed the amounts recognized under Medicare for changes in prevailing charge levels.

Any physician in the State may elect to participate or not to participate in the Medicare/Medicaid fee schedule program by giving 30 days' notice to the Secretary. He may later rescind his participation by 90 days' notice to the Secretary and to his patients. If a physician participated, he would agree to accept the fee schedule as payment in full, with no deductible or coinsurance amounts, and may elect to receive monthly payments on the basis of consolidated statements. A physician not electing to participate in the fee schedule would be paid on the basis of present reimbursement programs, subject to deductible and coinsurance.

Any fee schedule and the names and addresses of all participating physicians would be made public in the state by the Secretary or by the state with the approval of the Secretary.

Coinsurance and deductibles of patients of participating physicians would be collected by deductions of 1/12 the amount from monthly Title II checks (Old Age, Survivors, Disability) or by increasing Part B monthly premium by 1/12 of the amount, or by treating any amount due as an overpayment by the Secretary.

The bill then makes technical amendments to Medicare and amends Medicaid to integrate it with Medicare so far as concerns payments to physicians on a fee schedule basis.

We believe that this bill in proposing its unprecedented system of price controls, is both arbitrary and discriminatory, and raises serious constitutional questions. It would create extreme hardships and inequities for both physicians and patients. It would cause major disruptions in the delivery of health care and would exacerbate existing shortages.

The AMA does not support the basic approach of H.R. 6699, nor the bill itself, in its proposals for revisions in reimbursement for physician's services. The bill provides for an arbitrary schedule of fees controlled by an artificial ceiling selected only on the criteria of predetermined levels of expenditures. The bill is grossly unfair and could cause immediate rollbacks in reimbursement for most physicians. Under the bill the authority to set the schedule of fees is vested in the Governor. Furthermore the creation of uniform fees throughout the state does not recognize the many factors influencing the free market place which has caused existing variations. Such a proposal does not take into consideration such factors as costs of living, costs in providing proper medical services, and the quality of life of particular geographic locations. Hardships and inequities for physicians and particularly for patients would be created by the bill, and it would aggravate existing shortages and would curtail availability of health services for the elderly and the poor.

It is our belief that Medicaid costs to the states would be increased if such a bill were passed. Since responsibility for state Medicaid expenditures is in the Governor, the bill would vest a conflicting role in him by giving him authority to establish physician fees controlling Medicare and Medicaid reimbursements. We believe that physicians and their patients should be free to decide the method of payment for services.

In addition it would be grossly unfair and misleading to publish fees and lists of physicians taking assignments and holding them out exclusively as the "participating" physicians under Medicare. The effect of such a publication would be the public view that beneficiaries are directed to listed physicians. Furthermore, physicians who presently directly bill Medicare patients are in fact participating in Medicare in accordance with the Medicare law. It should be noted that the bill would cause an increasing shift from assignments to direct billing.

The role of the state medical societies under H.R. 6699 (which role can be filled by "equivalent organizations") is at best precatory. Moreover, a most difficult role would be created in attempting to reconcile, into a uniform schedule for recommendation to the Governor, the differences in usual and customary fees of all physicians (metropolitan, rural, specialty, etc.) in all areas of the state.

In such roles the state societies are placed in a precarious legal status, e.g. with reference to application of the Sherman Act.

Payment for physician services should be recognized at the usual, customary, and reasonable levels in the area of practice of the physician. Any program which creates economic barriers to prevent free choice is unfair, would create classes of care, and affects availability.

We would urge you not to adopt this or similar legislation which would have the effect of imposing fee schedules upon physicians. Such a system would be detrimental to quality patient care.

VI. Conclusion

Mr. Chairman, as final remarks we would like to express to you again our concern over increased health care costs. These costs affect all people. Too often in conversation we speak in terms of providers and consumers when we are discussing the health care sector of our economy. It is, however, necessary to keep in mind that in health care, in the final analysis, we are all consumers, and we are all, therefore, subject to the same factors which affect the costs, the quality and the availability of health care.

In the health care sector there is no doubt that costs have increased rapidly. However, we must look closely at the causes for these increases and not be hasty in drawing conclusions and in imposing "solutions" until we are certain that we have reconciled the solutions with the problems.

For example, in Medicare, it has been stated that physicians' fees must be controlled so that they do not "lead" the inflationary spiral. Nevertheless, as we have pointed out earlier, physicians' fees in Medicare have never led, but instead, have followed inflationary trends. Before considering additional controls on physicians' fees, we would urge you to subject to close scrutiny the present effects of Medicare regulation and to review closely the controls which already exist on physicians' fees are compared, not only to other segments under Medicare, but to all segments of our economy.

Physicians' fees are presently limited by the 75th percentile which in turn are paid for by Medicare at 80% and in turn are limited in increase by an economic index. What additional controls are now seriously to be considered? We urge against consideration of such controls as fee schedules or the provisions of H.R. 13080 discussed above. We urge that a careful evaluation be made of the effect of physician reimbursement controls implemented in Medicare. For instance, what has been the extent of their effect on charges in the private sector? To what extent are the private patients in effect being called upon to subsidize the Medicare and other government health programs? What is the effect on quality and availability when reimbursement is not realistic?

To the extent that reimbursement revision is now considered because of costs attributed to utilization it is our opinion payment controls are not the answer. Reimbursement for individual services should not be tied to any question of utilization. The PSRO program, only recently established and only partially implemented, is intended as the vehicle to review appropriateness of care under public programs. Its effect on total costs under Medicare is unknown at this time. It could well be that costs saved in relation to the amounts expended for an effective operation by the PSRO will be minimal as many indviduals project. Nevertheless the medical profession is cooperating with the PSRO program in order to assure its effectiveness to the extent possible.

Overutilization or abuse are not issues which should be a part of the basis for determining appropriate levels of reimbursement for Medicare services. Although such improper practice can occur it is in fact in an extremely small number of cases and is the subject of other mechanisms for cost control. Such an attempt to include these objectives in determining Medicare reimbursement clouds the more essential issue in any meaningful Medicare reimbursement revision.

That basic question no longer to be masked behind extraneous questions of utilization or abuse, is whether the Congres is willing to fulfill its major obligation of fair payment for service rendered comparable to payments made in the private sector. The Congress cannot continuously adjust the reimbursement schedule in order to meet budgetary objectives and continue to hold out Medicare coverage as comparable to that in the private sector. If budgetary objectives are to prevail, at what point will Congress finally settle? It must be kept in mind that limitations on physician reimbursement that are measured in terms of budgets cannot be separated from resulting dissatisfaction by patients and by physicians and by decreasing rates of assignment.

We believe that Medicare payments to physicians can and should be revised. However, payment mechanisms should reflect the responsibility which Congress has earlier decided should be in the public realm. Congress, by its enactment of Medicare, stated that it desired to provide a continued high level of quality medical care to Medicare beneficiaries financed by the public. That challenge is being met. However, the corollary is that quality services must be paid for at a proper level. That responsibility cannot be shirked by Congress. That responsibility cannot be ignored. Congress should recognize that responsibility and address it in an appropriate and responsive manner by adopting a physician reimbursement policy under Medicare recognizing usual and customary charges of physicians. In addition, unfair economic controls, including the onerous "economic index", should be repealed. We are certain that such positive responses by Congress will result in increased assignments, in more satisfied beneficiaries, and in more nearly approaching the initial intent of Congress to provide to the patient quality care of his choice.

Mr. Chairman and members of the Subcommittee, we urge you to consider our recommendations positively. In closing, we would again like to extend our offer to work with you in developing a program which fairly addresses the concerns of physicians and answers the concerns of Medicare beneficiaries.

Mr. Rostenkowski. Thank you, gentlemen.

I think we can agree that the lower fees charged and reimbursed in rural areas is not the only consideration of physicians chosing a practice location. Probably it is not the main consideration that induces physicians to prefer to practice in cities rather than rural areas.

But, don't you think that financial considerations play some part in the decisions on where they set up their practice?

Dr. Beddingfield. In case of a young physician finishing his training getting ready to hang out his shingle, I don't think it plays an important part.

I believe it would be a very minor part. I think—and our studies have indicated, very frankly—that the desire of the physician's spouse is the most important consideration, and the next are the availability of hospital privileges, the availability of colleagues and for a professional atmosphere in which to practice, environmental concerns, and so forth.

I can't say that it doesn't play any part but I believe it is way down the scale, and we have data to support that.

Dr. Holden. Mr. Chairman, I had an opportunity recently to participate in discussions with the medical profession in Great Britain, Belgium and France, and these same questions were talked about amongst us and particularly with regard to France. I was impressed by what they said about the distribution of physicians.

Most physicians graduate from medical school in the vicinity of Paris and want to settle there because that is the metropolitan center of the country.

Various numbers of other physicians want to go to the south of France where the climate is good and, regardless of the inducement offered them in the northern part of France, which is industrial, rainy, cold and unpleasant, they have a dickens of a time getting physicians in the northern part of France.

It is a choice of an individual—a choice that an individual makes on something more than just income.

Mr. Rostenkowski. What do we do about it?

How do we disperse these physicians?

Dr. Holden. I think the National Health Service Corps serves a good purpose. At the present time, we have information which makes us believe that approximately 40 percent of those who go into rural and depressed areas are staying there.

With this continuing maybe over a period of years, we might have a cadre of physicians who are ready and willing to serve in these areas.

I grew up in—you could call it a depressed area—and later moved away; there was not any opportunity there finally, and I had to move away and my family moved away.

This is a thing which is very difficult to solve and will not be solved by just money.

Mr. Rostenkowski. In another area, the Association of Blue Shield Plans suggested in their prepared testimony that the elimination of the deductible and substitution of a higher coinsurance would reduce the administrative workload for physicians and thereby eliminate what is a maior disincentive for physicians to accept assignment.

Do you agree with this and how much effect do you think it would have?

Dr. Beddingfield. I will be glad to attempt to answer that.

Mr. Rostenkowski. Proceed.

Dr. Beddingfield. I think it is an idea worthy of study. Before applying it across the board nationwide I think on behalf of research authority which I believe BHI already has, it could be tried. The mass—the avalanche of paperwork in attempting to cooperate with Government requirements—is overwhelming in a physician's office, and anything that would strain that, anything that would make it more acceptable, would encourage physician participation not only because this is one of the major deterrents to participation, not only the level of reimbursement being constantly under fire and newer restrictions of lower percentiles and so forth, but the paperwork itself is a very real problem.

In shifting this around to fund a deductible, I think it ought to be tried in selected areas and results studied.

If it proves to be feasible, apply it across the board.

Mr. Rostenkowski. Any comments, Doctor?

Dr. Holden. No, sir.

Mr. Rostenkowski. Yesterday the Senate Finance Committee approved an amendment sponsored by Senator Talmadge intended to combat fraud and abuse in medicare and medicaid.

Have you had time to form any opinion about the amendments, especially as they concern PSRO's?

Dr. Beddingfield. I was at the Senate Finance Committee hearings when Senator Moss appeared as a witness with the first revelation to the subcommittee.

We have now reacted to that in a preliminary way, it was only yesterday that I had even seen the full report of the Subcommittee on Aging, Senator Moss's report. I am not aware of the PSRO amendments that would apply. I have not seen amendments approved by the committee. We share the concern of Senator Moss and the Senate Finance Committee, and we know you are also concerned about fraud. We would offer our assistance in helping the Federal Government to ferret out fraud and prosecute anyone accused of fraud.

Dr. Holden. I will reiterate that as chairman of the AMA Board of Trustees I speak for the policy of the association, which is actually to cooperate in any way, shape, or form that we can to eradicate the fraud and abuse which is alleged as going on.

You must realize that medical societies, as they exist around the country, are only able to report incidents which to them seem to fall into these categories.

On occasions they have reported them and little or nothing ever came of them. We would like to see a more forceful position be taken by the agencies that have within their power the ability to prosecute and obtain redress on these people.

Mr. ROSTENKOWSKI. Mr. Duncan.

Mr. PETERSON. Mr. Chairman, the association indicated its support for objectives of the legislation you mentioned specifically and certainly we offer our assistance to achieve goals and objectives of the legislation.

Mr. ROSTENKOWSKI. Thank you.

Mr. DUNCAN. Thank you, Mr. Chairman.

I want to thank the panel for their usual good presentation.

Let me ask you: Representative Symington a few moments ago indicated that in Missouri they had had either 14 or 16 counties that did not have a physician.

I have seen this in my own State, and as you indicated it is not always money or financial consideration.

Instead of having higher remuneration for physicians in the urban centers, what would you think if you had a little higher figure in the rural communities to encourage physicians to go into the areas.

It would be a factor. As I say, it is not the complete thing, but it would help.

Dr. HOLDEN. Well, if the inducement produces a higher income or maybe some other benefit, perhaps a tax incentive, it could help.

Mr. DUNCAN. This reverses the situation?

Dr. HOLDEN. Well, it would be an enticement. I think if you tried it I think it might be a factor which would work in some areas but it would not be the total solution.

Mr. DUNCAN. It would be difficult to implement, I know that.

Dr. HOLDEN. Well, you would have to change human nature to get people to move, let us say, back to the farm. You know the old saying.

Mr. DUNCAN. Well, what are your thoughts on the physician extenders?

I think the doctor from Carolina wanted to answer.

Dr. HOLDEN. Dr. Beddingfield had considerable experience in this field and I would like to refer it to him.

Mr. DUNCAN. Yes, I would like to hear him.

Dr. BEDDINGFIELD. I think this is a valuable resource and I had pleasure in the last 7 or 8 years to be actively involved.

To start with, a physician's assistant program was initiated in North Carolina at Duke and we have been heavily involved in the development of that particular program through modification of our State Medical Practice Act, through physician policy statements from medicine, and very shortly after that through the nurse practitioner program and development of satellite clinics. Under a current program of our Governor, the legislature has funded money for a network of satellite clinics across the State.

This has been very successful. I have seen instances where the development of a satellite clinic under the supervision and direction of a nearby, but not present, on-the-site physician has developed a complex which attracted a physician who came in.

So, rather than discouraging a physician from settling there I think this can ultimately provide a favorable climate for a physician to come in because it is well demonstrated there is a need that adequate remuneration occur even in such an isolated area.

A team approach could also be developed. I think this is a very commendable thing which needs to be further explored and expanded.

Many, many patients are being served by these. For example, if I might continue for a second, in one very rural county in North Carolina, which is adjacent to the county in which I live, one satellite clinic was established some 3½ years ago. This has proved successful, so that there are now two additional satellite clinics in other small communities within that same county. Also under the National Health Service Corps program, two service corps physicians have now come in to help man the three clinics along with practitioners.

Mr. DUNCAN. You don't know of any great opposition among your profession against the extension of physician assistants?

Dr. BEDDINGFIELD. Yes, I think there is some opposition. There is not unanimity.

Mr. DUNCAN. Yes, I am sure of that.

Dr. BEDDINGFIELD. But I would have to say, based on policy statements by professional and medical organizations, that once this is studied the preponderant majority opinion is to support the cautious program development of physician extenders on a broad experimental basis.

I believe that is the status of things today.

Mr. DUNCAN. I would like to yield to my colleague from North Carolina.

Mr. MARTIN. I appreciate that because I have a related question.

In an appearance prior to your appearance, the statement of Mr. Symington included support for a bill he and Mr. Duncan introduced, H.R. 15152, and I am sure there are other numbers for identical bills introduced, but this would provide for medicare payments to physician extender services rendered under supervision of a physician or rendered in the physician's office or at a place where the physician is physically present and so forth.

That is drawing a distinction of providing reimbursement as long as a physician extender is under supervision of a physician, but no longer requiring physical presence.

Has your association taken a position? I know we discussed it in an earlier appearance.

Dr. HOLDEN. We have not taken a position on that bill specifically but Dr. Beddingfield can tell you where it is in the legislative council.

Dr. BEDDINGFIELD. The subject is on the agenda for a meeting here this Saturday in Washington.

I am personally familiar with the type of proposal. In fact, as you know, we had correspondence about this particular topic. I might point out, in addition, that under research authority HEW has, and has had for some time, they have just launched a program of doing this on an experimental basis where they made a decision of supervising certain documented physician extenders.

There have been some detailed studies through a grant by Stanford University, I believe, of these practices and they have extracted therefrom certain typical practices they wanted to study under experimental authority that you granted them in recent law.

They have as of 2-weeks ago permitted payment under medicare to services performed by a physician extender in remote satellite cities. This is just starting out and I happen to be one of the participants in that experiment.

I am certain there is no feedback on it yet. I think there should be feedback prior to your consideration of a bill applying it across the board.

Mr. MARTIN. Is it your expectation that your discussion this Saturday will reach a conclusion or do you think it will be deferred until after the HEW experiments are concluded?

Dr. BEDDINGFIELD. Under our structure, our professional organization, the council on legislation is an advisory body. We advise the board of trustees which Dr. Holden chairs.

We have a pretty good batting average because they accept about 95 percent of our recommendations, so I would say the prognosis ought to be pretty good.

Mr. PETERSON. If I may make a comment, we had examined this general physician assistants concept before, and it has received favorable acceptance.

We would like to review the particular bills you mentioned, and we certainly will be happy to advise the committee of the reaction to the bills.

Mr. MARTIN. I wonder, Mr. Chairman, if we could arrange for unanimous consent to have a statement submitted by them after concluding their consideration and, if it is timely, that is, if we have not closed the hearings, to have it included.

Mr. ROSTENKOWSKI. You say the meeting is Saturday?

Dr. BEDDINGFIELD. Yes.

Mr. ROSTENKOWSKI. Fine.

Dr. BEDDINGFIELD. We will be pleased to respond this way.

[The response can be found at p. 609.]

Mr. ROSTENKOWSKI. Thank you, gentlemen.

Dr. HOLDEN. Thank you very much, Mr. Chairman and members of the committee.

Mr. ROSTENTOWSKI. Mr. Morris.

Welcome to the committee, Mr. Morris, and if you will, identify yourself and proceed with your statement.

STATEMENT OF LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT, NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

Mr. MORRIS. Thank you.

Mr. Chairman and members of the committee, my name is Lawrence C. Morris, senior vice president of the National Association of Blue Shield Plans.

The association consists of 70 not-for-profit, medical care prepayment plans that cover 72 million private subscribers and serve 12 million medicare beneficiaries.

In 1975, the 32 Blue Shield part B carriers processed 51 million medicare claims, amounting to 63 percent of the total part B claims processed. We are obviously concerned with our responsibilities in this program.

It is a privilege to discuss some of the issues involved in physician reimbursement under medicare. I will review our major points within the time allotted, and ask that our entire statement be inserted into the record.

Mr. Rostenkowski. Without objection.

Mr. Morris. Thank you.

Mr. Chairman, we see three basic factors which influence physicians not to accept assignment under medicare part B. The first of these is uncertainty.

For example, when several physicians treat the same patient, it is difficult for them to know whether the deductible has been satisfied.

It becomes administratively simpler to refuse assignment and submit a single bill to the patient. This eliminates having to bill for the coinsurance and rebill for the deductible if it has not been met.

In these cases, refusal of assignment may be an indicator of dissatisfaction with the program benefit structure, and not necessarily with the allowances.

If this is the case, substituting coinsurance alone for coinsurance plus a deductible would eliminate the problem, but this would be expensive unless the coinsurance percentage were raised significantly.

There would, however, be substantive savings in the administrative cost.

A second factor is the dual billing required if the physician does accept assignment. He must bill both the patient and the Government. This is one of the few programs in existence that simultaneously limits the physician's charge and increases his overhead.

If there is to be third-party payment, at least one claim is inevitable. The second bill can be avoided only by refusing assignment and billing the patient directly.

Another reason why some physicians refuse assignment is that they believe the medicare reimbursement level is arbitrary. It is based on frozen data, from 18 to 30 months old. It is governed by an economic index which they may not feel bears any real relationship to their costs.

The effect of this, of course, varies substantially from specialty to specialty and many physicians may not be affected in any major way.

Some are, however, and react by opting out of the program to deal directly with their patients. Government has a clear duty to limit the reimbursement level, but the impact of its method on the attitude of physicians does result in lost assignments.

There are undoubtedly other factors which may influence the physician assignment rate. They include: The amount of a practice covered by medicare; the population distribution in the area of practice; the income level of the patients; how well the physician knows the patient; how long he has been treating the patient; the length of treatment anticipated; and many other variables that enter into a physician-patient encounter.

We are sure the committee recognizes that physician assignment need not be a major priority in medicare. The program can function adequately as a means of helping the elderly defray medical costs at its current assignment rate. However, if the committee does wish to increase assignments, the critical areas are simplicity in the reimbursement, minimal cost of claiming benefits, and a reimbursement level acceptable to physicians, particularly in the geographic and specialty areas heavily involving older people.

Mr. Chairman, you also requested our opinion on requiring physicians to accept assignment for all their patients as a condition for receiving any direct payment from medicare.

Clearly an all-or-nothing assignment is feasible. Blue Shield has worked for years with the concept of participating doctors. We believe that if certain conditions are met, this concept could also work for any other program.

Those conditions are, first, that the reimbursement be either income-related or a reasonable approximation of the physician's charges for nonmedicare patients; second, that the billing requirements not increase overhead unduly; and third, that the administration of the program create fundamental confidence on the part of the physicians.

You have also asked about using charge differentials in medicare to encourage physicians to practice in rural areas. We do not believe that financial incentive or the lack of it is a major element in this problem.

We know, for example, that some physicians who practice in underserved areas have heavy medicaid patient loads and earn substantial incomes.

However, despite the financial incentives, few physicians elect to practice in these areas. There appear to be at least three major reasons: professional isolation; lack of support facilities; and family preferences.

Professional isolation creates unreasonable work loads, both from unmanageable patient-to-physician ratios and from a lack of coverage by other physicians for time off. It also denies a physician professional growth opportunities, since he cannot easily confer with colleagues on medical problems.

Modern medicine and its advanced technology has made the availability of convenient support facilities—hospitals, X-ray and so forth—important considerations in a physician's choice of location. These are not usually available in rural areas.

And finally, the urban-educated physician, frequently with a spouse from the city, typically prefers an urban environment, or at least ready access to one, for his personal and family life.

For these reasons we do not believe any financial incentive which could reasonably be built into medicare would have a primary effect in relieving the physician shortage in rural areas.

Any effort to relieve the shortage should concentrate on such factors as we have identified, and should probably begin with the selection process for medical students.

The committee has asked whether it is feasible and desirable to reimburse physicians according to fee schedules rather than customary and prevailing charges. You also asked about the role of relative value scales.

Physician reimbursement is a means, not an end. The important thing is whether the means of reimbursement adequately serves the purpose of the program.

There is little doubt that fee schedules are feasible; however, their desirability depends on the program's objective. Whether medicare will be a paid-in-full program based on reasonable charges or a program to assist its beneficiaries within a controlled liability should be as much in focus as the method of reimbursing physicians.

Blue Shield recognizes the importance of holding medicare expenditures within reasonable bounds. The carrier plans have worked with the Social Security Administration to accomplish this objective.

Unfortunately, Mr. Chairman, inflation has caused the original objectives of a paid-in-full program to conflict with the need to limit the Government's financial liability.

Medicare part B cannot continue to be regarded as a paid-in-full program and at the same time, attempt to control program costs at a level which does not recognize economic realities.

In 1965, NABSP urged Congress to adopt the Federal employee program approach for medicare. FEP at that time was a $7,500 income limit, participating contract, fee schedule program.

This would have made Government liability more predictable. We believed that this approach was deliverable at that time. However, the opportunity has passed to convert the variable charge methodology of medicare to scheduled coverage without some significant problems.

This has developed for a number of reasons.

First, a schedule must be designed for a specific objective. If the objective is to limit program liability, it can be set at essentially any level.

If its objective is to pay the patient's cost in full, it should be related either to income levels or to usual charge levels.

To move medicare to a schedule approximating usual charges would be inflationary, in that those physicians who charge less than the average would be expected to move up, and many of those who charge more than the average would not move down to accept the schedule.

An additional consideration is the extent to which physicians have confidence in Federal reimbursement policies. They have seen the rules for medicare reimbursement change before.

They have also seen Government single them out for special treatment, more adverse than that of other groups, in the economic stabilization program.

It is questionable whether most physicians would accept that the stated conditions of participation in a fee schedule program would remain unchanged.

Some reasonable provision for opting out of the all-or-none assignments with due notice will probably be necessary to broad participation.

However, Mr. Chairman, we suggest that in your current deliberations, the committee not lose sight of the basic reasons underlying the prevailing fee methodology. The reasons are at least as valid today as they were in 1965.

Until the mid-1960's, almost all of Blue Shield's coverage was on fee schedules. For the most part, schedules were linked to income limits, in an arrangement where different income schedules paid different fees for the same procedure, at, naturally, different premiums.

This arrangement served to implement the principle that fees should be consonant with the patient's ability to pay. Most physicians appreciated this reasoning and became participants.

The movement away from fee schedules was caused by economic and clinical changes. These primarily included specialization and inflation.

Specialization caused more work to be done by consultants who lacked ongoing relationships with patients, and who tended to standardize their charges, expecting the same compensation from all patients.

Inflation caused fee schedules which had survived for years at the $4,800, $6,000, or $7,500 level to become obsolete, as increasing numbers of patients earned incomes which put them beyond the limits.

This, in turn, eroded the principle of charges based on the income of the patient. Medicare in the very beginning recognized these trends and applied the prevailing fee approach. The reasons for this decision are even more prevalent today than they were then.

Mr. Chairman, you also asked for our comments on the use of "relative value scales." If the Congress elects to use regional fee schedules, a relative value scale would offer the advantage of consistency between areas.

However, it should be remembered that when a relative value scale is used for reimbursement, it becomes a fee schedule; the difference is simply in its construction, not in the end product.

The real key to the whole area of concern with reimbursement is for Congress to settle upon a single objective—payment in full or control of the Government's liability.

We are not here to advocate either objective. We simply recommend that Congress make such a choice, and clearly inform the public, the providers of care, and the program administrators of the decision.

Finally, we were invited to discuss the results of the experiments or ongoing reimbursement programs which are possible alternatives to or improvements in the present medicare reasonable charge system.

Broad experimentation is difficult in medicare. It is the largest health financing program, private and public, in the Nation.

More than 22 million people in every conceivable geographic and demographic circumstance are its beneficiaries. We know of no substitute currently in existence for fee-for-service reimbursement that can accommodate such a massive and diverse program.

There are a number of experimental programs being implemented locally by cooperative efforts between providers, carriers and subscribers.

These include programs to permit physicians and patients to participate in the economic results of efforts to reduce utilization, and payment of one set fee by a specific diagnosis in the medical as well the surgical area.

These methods, however, would not be applicable to medicare reimbursement on a national level, since they depend on joint experimentation and close working relationships within a given community.

Far from being negative toward experimental reimbursement, we applaud Congress' efforts to introduce experimentation into medicare.

We expect useful alternatives will develop from this experimentation, and be effective in specific geographic areas. We hope that as few obstacles as possible will be raised against their use. But the very massiveness of medicare dictates a conservative approach to the basic national reimbursement method.

In summary, we recognize that the reimbursement method is a key element in medicare and that it is important to keep a control over expenditures.

However, we repeat that the reimbursement method is not an end but must be designed to satisfy a specific objective within the program.

We appreciate this opportunity to present our views.

[The prepared statement follows:]

Statement of the National Association of Blue Shield Plans, Presented by Lawrence C. Morris, Senior Vice President

Mr. Chairman, I am Lawrence C. Morris, Senior Vice President of the National Association of Blue Shield Plans. The Association consists of 70 not-for-profit, medical care prepayment Plans that cover 72 million private subscribers and serve 12 million Medicare beneficiaries. In 1975, the 32 Blue Shield Part B carriers processed 54 million Medicare claims, amounting to 63 percent of the total Part B claims processed. We are obviously concerned with our responsibilities in this program.

It is a privilege to discuss some of the issues involved in physician reimbursement under Medicare. I will review our major points within the time allotted, and ask that our entire statement be inserted into the record.

PHYSICIAN ASSIGNMENT CONSIDERATIONS

The Committee has asked us to comment on factors in the present Medicare reimbursement system which influence physicians' decisions to accept or reject assignment of claims. A second consideration is whether people would be better served if the federal government required physicians to accept assignments in all cases as a condition of receiving any direct reimbursement from the Medicare program. The two issues are closely related.

We have been acutely aware of the declining trends in Part B assignment rates. At one time, the assignment rate was 61.5 percent. This January it dropped to a low of 47.3 percent. By March, it had moved up slightly to 50.7 percent. The range also varies nationwide going from 68.6 percent on the East Coast to 34.3 percent on the West Coast.

While a declining assignment rate does not necessarily reflect the number of physicians who do not accept Medicare allowances, the decline does seem to signal physician dissatisfaction. With allowances for the deductible and coinsurance, Medicare is intended to be a full payment program. For any program of this kind to succeed, be it government or private, the reimbursement method must meet at least two basic objectives. It must guard against artificially high costs, and it must protect the patient's access to a reasonable range of physicians who accept the program's reimbursement level. To do this, it must encourage physicians to participate and accept a reasonable reimbursement level. Failure of either objective will eventually undermine the program.

Mr. Chairman, we see three basic factors which influence physicians not to accept assignment under Medicare Part B. The first of these is uncertainty. For example, when several physicians treat the same patient, it is difficult for them to know whether the deductible has been satisfied. It becomes administratively simpler to refuse assignment and submit a single bill to the patient. This eliminates having to bill for the coinsurance and re-bill for the deductible if it has not been met. In these cases, refusal of assignment may be an indicator of dissatisfaction with the program benefit structure, and not necessarily with the allowances. If this is the case, substituting coinsurance alone for coinsurance plus a deductible would eliminate the problem, but this would be expensive unless the coinsurance percentage were raised significantly. There would however, be substantive savings in administrative cost.

A second factor is the dual billing required if the physician does accept assignment. He must bill both the patient and the government. Billing twice increases the doctor's overhead expenses. This is one of the few programs in existence that simultaneously limits the physician's charge and increases his overhead. If there is to be third party payment, at least one claim is inevitable. The second bill can be avoided only by refusing assignment and billing the patient directly.

Another reason why some physicians refuse assignment is that they believe the Medicare reimbursement level is arbitrary. It is based on frozen data, from 18 to 30 months old. It is governed by an economic index which they may not feel bears any real relationship to their costs. The effect of this of course varies substantially from specialty to specialty and many physicians may not be affected in any major way. Some are, however, and react by opting out of the program to deal directly with their patients. Government has a clear duty to limit the reimbursement level but the impact of its method on the attitude of physicians does result in lost assignments.

There are undoubtedly other factors which may influence the physician assignment rate. They include: the amount of a practice covered by Medicare; the population distribution in the area of practice; the income level of the patients; how well the physcian knows the patient; how long he has been treating the patient; the length of treatment anticipated; and many other variables that enter into a physician-patient encounter.

We are sure the Committee recognizes that physician assignment need not be a major priority in Medicare. The program can function adequately as a means of helping the elderly defray medical costs at its current assignment rate. However, if the Committee does wish to increase assignments, the critical areas are simplicity in the reimbursement, minimal cost of claiming benefits, and a reimbursement level acceptable to physicians, particularly in the geographic and specialty areas heavily involving older people.

Mr. Chairman, you also requested our opinion on requiring physicians to accept assignment for all their patients as a condition for receiving any direct payment from Medicare.

Clearly an all-or-nothing assignment is feasible. Blue Shield has worked for years with the concept of participating doctors. We believe that if certain conditions are met, this concept could also work for any other program. Those conditions are, first, that the reimbursement be either income-related or a reasonable approximation of the physician's charges for non-Medicare patients; second, that the billing requirements not increase overhead unduly; and third, that the administration of the program create fundamental confidence on the part of the physicians.

If this approach is taken, then differing responses must be expected from different medical specialties. The effect of blanket assignment will be uneven, because some doctors devote more of their practice to Medicare patients than do others.

However, Mr. Chairman, the most important thing to remember here is that requiring physicians to make a choice does not get to the heart of the matter. It will not solve the major problem. The real issue is the relationship of the program to the physicians who service its beneficiaries.

PHYSICIAN SHORTAGES IN RURAL AREAS

You have also asked about using charge differentials in Medicare to encourage physicians to practice in rural areas. We do not believe that financial incentive (or the lack of it) is a major element in this problem.

We know, for example, that some physicians who practice in underserved areas have heavy Medicaid patient loads and earn substantial incomes. However, despite the financial incentives, few physicians elect to practice in these areas. There appear to be at least three major reasons: professional isolation; lack of support facilities; and family preferences.

Professional isolation creates unreasonable work loads, both from unmanageable patient-to-physician ratios and from lack of coverage by other physicians for time off. It also denies a physician professional growth opportunities, since he cannot easily confer with colleagues on medical problems.

Modern medicine and its advanced technology has made the availability of convenient support facilities—hospitals, laboratories, X-ray and so forth—important considerations in a physician's choice of location. These are not usually available in rural areas.

And finally, an urban-educated physician, frequently with a spouse from the city, typically prefers an urban environment—or at least ready access to one—for his personal and family life.

For these reasons, we do not believe any financial incentive which could reasonably be built into Medicare would have a primary effect in relieving the physician shortage in rural areas. Any effort to relieve the shortage should concentrate on such factors as we have identified, and should probably begin with the selection process for medical students.

FEE SCHEDULES, CUSTOMARY AND PREVAILING CHARGES AND RELATIVE VALUE SCALES

The Committee has asked whether it is feasible and desirable to reimburse physicians according to fee schedules rather than customary and prevailing charges. You also asked about the role of relative value scales.

Physician reimbursement is a means, not an end. The important thing is whether the means of reimbursement adequately serves the purpose of the program. There is little doubt that fee schedules are feasible; however, their desirability depends on the program's objective. Whether Medicare will be a paid-in-full program based on reasonable charges or a program to assist its beneficiaries within a controlled liability should be as much in focus as the method of reimbursing physicians.

Blue Shield recognizes the importance of holding Medicare expenditures within reasonable bounds. The carrier Plans have worked with the Social Security Administration to accomplish this objective. Unfortunately, Mr. Chairman, inflation has caused the original objectives of a paid-in-full program to conflict with the need to limit the government's financial liability. Medicare Part B cannot continue to be regarded as a paid-in-full program and at the same time, attempt to control program costs at a level which does not recognize economic realities.

In 1965, NABSP urged Congress to adopt the Federal Employee Program approach for Medicare. FEP at that time was a $7,500 income limit, participating contract, fee schedule program. This would have made government liability more predictable. We believed that this approach was deliverable at that time. However, the opportunity has passed to convert the variable charge methodology of Medicare to scheduled coverage without some significant problems.

This has developed for a number of reasons.

First, a schedule must be designated for a specific objective. If the objective is to limit program liability, it can be set at essentially any level. If its objective is to pay the patient's cost in full, it should be related either to income levels or to usual charge levels. To move Medicare to a schedule approximating usual charges would be inflationary, in that those physicians who charge less than the average would be expected to move up and many of those who charge more than the average would not move down to accept the schedule.

An additional consideration is the extent to which physicians have confidence in federal reimbursement policies. They have seen the rules for Medicare reimbursement change before. They have also seen government single them out for special treatment, more adverse than that of other groups, in the economic stabilization program. It is questionable whether most physicians would accept that the stated conditions of participation in a fee schedule program would remain unchanged. Some reasonable provision for opting out of the all-or-none assignments with due notice will probably be necessary to broad participation.

However, Mr. Chairman, we suggest that in your current deliberations, the Committee not lose sight of the basic reasons underlying the prevailing fee methodology. The reasons are at least as valid today as they were in 1965.

Until the mid-1960's, almost all of Blue Shield's coverage was on fee schedules. For the most part, schedules were linked to income limits, in an arrangement where different income schedules paid different fees for the same procedure, at, naturally, different premiums. This arrangement served to implement the principle that fees should be consonant with the patient's ability to pay. Most physicians appreciated this reasoning and became participants.

The movement away from fee schedules was caused by economic and clinical changes. These primarily included specialization and inflation. Specialization caused more work to be done by consultants who lacked ongoing relationships with patients, and who tended to standardize their charges, expecting the same compensation from all patients. Inflation caused fee schedules which had survived for years at the $4,800, $6,000 or $7,500 level to become obsolete, as increasing numbers of patients earned incomes which put them beyond the limits. This, in turn, eroded the principle of charges based on the income of the patient. Medicare in the very beginning recognized these trends and applied the prevailing fee approach. The reasons for this decision are even more prevalent today than they were then.

Mr. Chairman, you also asked for our comments on the use of "relative value scales." If the Congress elects to use regional fee schedules, a relative value scale would offer the advantage of consistency between areas. However, it should be remembered that when a relative value scale is used for reimbursement, it becomes a fee schedule; the difference is simply in its construction, not in the end product.

The real key to the whole area of concern with reimbursement is for Congress to settle upon a single objective—payment-in-full or control of the government's liability. We are not here to advocate either objective. We simply recommend that Congress make such a choice, and clearly inform the public, the providers of care, and the program administrators of the decision.

EXPERIMENTAL REIMBURSEMENT PROGRAMS

Finally, we were invited to discuss the results of experiments or ongoing reimbursement programs which are possible alternatives to or improvements in the present Medicare reasonable charge system.

Broad experimentation is difficult in Medicare. It is the largest health financing program, private and public, in the nation. More than 22 million people in every conceivable geographic and demographic circumstance are its beneficiaries. We know of no substitute currently in existence for fee-for-service reimbursement that can accommodate such a massive and diverse program.

There are a number of experimental programs being implemented locally by cooperative efforts between providers, carriers and subscribers. These include programs to permit physicians and patients to participate in the economic results of efforts to reduce utilization, and payment of one set fee by a specific diagnosis in the medical as well as the surgical area. These methods, however, would not be applicable to Medicare reimbursement on a national level, since they depend on joint experimentation and close working relationships within a given community. Far from being negative toward experimental reimbursement, we applaud Congress' efforts to introduce experimentation into Medicare. We expect useful alternatives will develop from this experimentation, and be effective in specific geographic areas. We hope that as few obstacles as possible will be raised against their use. But the very massiveness of Medicare dictates a conservative approach to the basic national reimbursement method.

CONCLUSION

In summary, we recognize that the reimbursement method is a key element in Medicare and that it is important to keep a control over expenditures. However, we repeat that the reimbursement method is not an end but must be designed to satisfy a specific objective within the program.

We appreciate this opportunity to present our views.

Mr. Rostenkowski. Thank you, Mr. Morris.

Mr. Morris, on page 3 you suggest that eliminating the deductible and substituting a higher rate of coinsurance would make it administratively easier for physicians and would encourage more physicians to accept assignment.

Have you conducted any demonstration projects or do you have program experience to support your contention?

Mr. Morris. Mr. Chairman, almost all of Blue Shield's private business is sold without deductibles and we sell benefits in two basic categories.

The base benefits are defined as surgery and hospital medical care and diagnostic radiology, things of this kind, and they are paid on a first dollar basis so there is no deductible.

There are other kinds of services in which patient decision can be a significant factor in determining utilization, let's say, office visits to physicians.

Those are frequently sold in a supplemental benefit package in which a deductible is incorporated.

There are a few major national accounts which incorporate a deductible in the basic program. It is our view, our observation, that the utilization trend is not vastly different between the two types of accounts.

I think the answer to the question is that our customary way of doing business is without a deductible and our results appear to be a higher level of satisfaction on the part of physicians, as demonstrated by their participation.

Mr. ROSTENKOWSKI. You suggest that the double billing required of physicians in accepting assignment discourages them in accepting assignment. Under the Fulton bill, 6699, 100 percent of the payment is made to the patient by the program and medicare then bills the patient for deductible plus the 20 percent coinsurance.

What do you think about a mechanism like this which puts the medicare program in the collection business?

Mr. MORRIS. I think, Mr. Chairman, it has potential for encouraging a significantly higher rate of assignment. We suggest it be put on an experimental basis before being legislated as appropriate for the whole program at once.

I believe it has potential for encouraging assignment.

Mr. ROSTENKOWSKI. Mr. Burleson.

Mr. BURLESON. No questions.

Mr. ROSTENKOWSKI. Mr. Duncan?

Mr. DUNCAN. I don't think I have any.

Mr. ROSTENKOWSKI. Thank you.

Mr. MORRIS. Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Dr. Bruckheim, welcome to the committee. Please identify yourself and proceed with your testimony and the committee is ready to receive it.

STATEMENT OF ALLAN H. BRUCKHEIM, M.D., MEMBER, COMMISSION ON LEGISLATION AND GOVERNMENTAL AFFAIRS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, ACCOMPANIED BY CARL B. HALL, M.D., PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Dr. BRUCKHEIM. Mr. Chairman and members of the subcommittee, I am pleased to be present today to present the views of the American Academy of Family Physicians in regard to physician reimbursement under the medicare program.

I am a member of the academy's commission on legislation and governmental affairs and currently serve as director of the family practice residency program at St. Joseph's Hospital in Yonkers, N.Y.

Seated with me, with his rather reassuring presence, is Dr. Carl B. Hall, who is a practicing family physician from Charleston, W. Va.

Dr. Hall is currently the president of the American Academy of Family Physicians.

Gentlemen, our testimony has been presented in written form and I would like to have it submitted as a whole and make a few additional comments as an aside, if it is acceptable with the committee.

Mr. BURLESON [presiding]. Without objection, it is acceptable.

Dr. BRUCKHEIM. Thank you, sir.

Originally, when medicare was initiated and the fee schedules were announced three words were made known to physicians "usual." "customary," and "prevailing."

"Usual and customary" are human words because we understand it as what we did normally in practices and usual fees we would charge to patients for any given services.

However, the last term "prevailing" turned out to be a computer-type term, a mechanical-type term, a term which was used to average things together to establish districts of supposed care and to separate the specialties from the family physician.

It was a hard one for us to understand because it could be readily changed. It could be made into different percentiles and coefficients could be added and artificial sectors could be made between doctors practicing in one area and another.

At the same time the Academy of Family Physicians was just starting on a program to give rebirth to the family doctor who would indeed eventually service the personnel and the people who lived in rural as well as in central city core areas, with doctor care being notably absent.

With the view of "prevailing," "usual" and "customary" became in fact a fee schedule and a fee schedule in fact was a fee schedule that lagged greatly behind the times.

It could be based upon costs and schedules which were 2 to 3 years old and limited to different percentiles. At no time did it actually represent the usual and customary fee schedule of the physician.

We found ourselves as family physicians separated from our brother doctors who are specialists and whose fee schedules were remarkably different than ours even though the services rendered were exactly the same in many instances.

We were further fragmented between urban doctor and rural doctor because they, too, had been caught up in the artificial fragmentation and artificial prevailing area situation so that the financial remuneration of the doctor practicing in a small rural area was ofttimes less than the doctor who practiced in the urban area.

In the family practice movement we discovered ways within the residency programs just starting at that time and now having grown to 281 to introduce physicians to the areas of medical need through a process of proctorship and preceptorship.

Doctors who were enrolled in training programs were asked to serve with practicing physicians in rural communities and regardless of the statements made heretofore that where you are born you like to stay. There is certainly a great deal to be said about the rural atmosphere if even you were a doctor born in Brooklyn where we had but one tree at one time.

By this means we hope to replace into these areas physicians who might service the populace and since family medicine is a philosophy and science which engages in total and complete medical care of the populace, it is easier for a physician to find acceptance in a small community and have enough for him to do over a long period of time rather than a specialist who needs a larger population as his supply of patients for the services he performed.

As time went on medicare divided us up and kept us back and kept the fee schedules which at that time were being controlled by prevailing down to the levels as mandated or as put forth by promulgations and recommendations.

I would like to make a point here about the reimbursement assignment situation discussed so well by some of the previous individuals.

Perhaps an anecdotal methodology might be a little different than the ones previously expressed. As a family physician in a small town of 17,000 people I charged $10 for an office call, however, my medicare profile was but $8.

If I accepted the assignment, that meant that the payment which would be made to me was 80 percent of $8, or $6.40. This was after I had sent in a form to medicare for reimbursement or to the local third-party carrier.

I was then entitled to charge a patient the additional 20 percent coefficient, in this particular case $1.60. It required a secondary billing on the part of my staff.

At that time stamps were cheap and only 10 cents, but now they are 13 cents, which increases the cost a little bit.

The patient had received a notification from medicare that I had already received $6.40 from them on the $10 bill, which would have normally been charged and here received a bill for $1.60 and we received a very irate letter from the young woman who asked for reimbursement to her, of the extra $4.80, which we had gotten from Uncle Sam, which didn't belong to us.

Thus in fact through the system the patient's not understanding of the fact that there were reimbursement formulas, coefficients, deductibles, and double billing, provided a lack of communication between the patient and the physician.

The costs are indeed enormous when you must bill a patient two times and when your essential fee structure is a low one such as $10 or $15 rather than the higher ones that might be charged by other specialists for surgical interventions and the like.

Therefore, it is the recommendation—and some of the recommendations have been made to you, that a good close look be made to reducing this remarkable difference between what was once called the general practitioner and the specialist, and providing a fee or a remuneration methodology which allows every physician to receive the same fee for the same service.

By this methodology you will cease to divide the urban physician from the suburban physician. By this methodology you may cease to divide the specialists from the so-called nonspecialists because in the intervening time the nonspecialists have indeed become specialists.

By reducing coefficients and double billing, the tremendous overhead on a doctor who may be receiving anywhere from 40 to 50 patients a day will be reduced to a reasonable portion and the additional expense thus will not be passed on to the physician in additional fees.

Dr. Hall is with me and I don't know if he has comments but we stand ready to answer any of your questions.

Mr. Burleson. Dr. Hall, do you have any comments?

Dr. Hall. I have no comments other than to answer questions.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYICIANS, PRESENTED BY ALLAN H. BRUCKHEIM, M.D.

Mr. Chairman and members of the subcommittee, I am pleased to be present today to present the views of the American Academy of Family Physicians in regard to physician reimbursement under the Medicare program. I am a member of the Academy's Commission on Legislation and Governmental Affairs and currently serve as Director of the Family Practice Residency Program at St.

Josephs Hospital in Yonkers, New York. Seated with me is Dr. Carl B. Hall who is a practicing family physician from Charleston, West Virginia. Dr. Hall is the current president of the American Academy of Family Physicians.

In view of the many issues which will be covered by these hearings and the relatively little time in which to do it, I will attempt to keep my remarks as brief as possible. I will not attempt to cover each topic included for discussion but will confine my testimony to those issues which are of primary interest to the family physician. Specifically, I would like to devote particular attention to topics four and five in the press release which was issued in regard to the hearings. These are: Differentials in Medicare reasonable charges between urban and rural areas, implications for present efforts to alleviate shortages of physicians in rural areas; and implications of Medicare reasonable charge differentials between primary care physicians and other physicians, and between various specialities, including implications for the supply of physicians choosing to practice in various fields.

As you may know, the American Academy of Family Physicians is the Nation's largest medical specialty organization representing over 37,000 family physicians. With a membership of this size, we receive frequent correspondence in regard to those issues of greatest concern to our individual members. One of the most difficult questions—if not the most difficult—which we are asked to answer by our members is why family physicians are reimbursed at a lower level than other types of physicians under the Medicare program and why physicians in rural areas are reimbursed at a lower level than physicians in urban areas. Although we know the rationale on which these practices are based, we find such rationale impossible to explain on the basis of logic.

On the one hand, the federal government has made a firm commitment to correcting both geographic and specialty maldistribution problems and has expended considerable funds to achieve this purpose. This is made abundantly clear in reviewing the health manpower legislation which recently has been under consideration in conference committee. On the other hand, the government's Medicare policy has had the effect of discouraging practice in those areas in which physicians are most needed and discouraging physicians from entering the specialty in which they are most needed. In our opinion, the dual fee situation which has arisen under Medicare is extremely counter-productive to the government's obvious desire to correct geographic and specialty maldistribution.

I should make it clear that we are not advocating the adoption of a standardized fee schedule for all physicians. We believe that with modifications, the usual and customary basis is the most equitable for both physicians and the government. Nor are we advocating the position that all physicians should receive the same reimbursement for a specific service or procedure regardless of what they customarily charge for that service or procedure. However, we adamantly are opposed to a system under which the reimbursement for family physicians and physicians in rural areas is automatically less than for physicians in other types of practice or in urban areas, regardless of the fact that their customary charges may be the same.

Under current medicare policies, physicians are reimbursed on the basis of the fee which they customarily charge for the same service or procedure and the prevailing charge of other physicians in that area for the same service or procedure. As I previously stated, we believe reimbursement should be relative to what the physician customarily charges. Furthermore, we recognize that from a practical standpoint, some upper limit must be placed on customary charges, and the determination of a prevailing charge is the mechanism which has been adopted to accomplish this. However, when different prevailing charge levels are established for family physicians and all other types of physicians or for rural physicians and all other types of physicians, the result is both discriminatory and detrimental to the improvement of the health care delivery system.

The Academy believes there should be one prevailing charge for a particular service or procedure, regardless of the specialty or geographic location within the state of the physician involved. Reimbursement should be limited to the physician's customary charge providing that it does not exceed the prevailing charge.

Under present reimbursement policies, the upper level of reimbursement for family physicians is less than for other types of specialists because two levels of prevailing charges have been established. We do not feel that it is equitable for a family physician—who may customarily charge the same as any other specialist—to be reimbursed at a lower level than the other specialist because he is subject to a separate prevailing charge level. In effect, his reimbursement is less because he is a family physician. Likewise, we don't feel it is proper for a rural physician to be reimbursed at a lower level than an urban physician solely because of the fact that he practices in a rural area and without regard to the fact he may customarily charge the same as the physician practicing in an urban area. All we are really advocating, then, is that family physicians and physicians in rural areas be entitled to receive the same reimbursement as any other physician if they customarily charge the same as other physicians.

The HEW regulations providing for the establishment of more than one prevailing fee level were issued in 1967. In instances in which we have been in contact with the Social Security Administration regarding these regulations, we have been told that the reason the prevailing charge should not be uniform is because this is the only way in which to preserve prevailing patterns of practice. That is, as we understand it, general practitioners have historically charged less, so a different prevailing charge should be applied to them. Of course, this completely overlooks the fact that since the regulations came into effect, family practice has become a specialty and virtually all young physicians entering family practice are graduates of residency programs, the same as any other specialist. We do not point this out to support a belief that Board certified family physicians or those graduating from a residency program should be entitled to any different treatment than any other physician, be he internist, pediatrician or non-Board certified family physician. On the contrary, as has been stated throughout this testimony, we believe all physicians should be treated the same as far as application of a prevailing fee is concerned. However, we do point this out in support of the position that the continued use of different prevailing levels does not preserve prevailing patterns of practice as they exist but perpetuates HEW's perception of the patterns of practice as they existed several years ago. It seems to us that if there is a single prevailing fee within a state and reimbursement is based on the individual's customary charge—so long as it doesn't exceed the prevailing charge—the existing patterns of practice will be reflected much more accurately than is currently the case.

We are aware of only one instance in which different prevailing levels have been applied to any specialty other than family practice. That is, we are aware of numerous instances in which there is one prevailing level for family physicians (including those who classify themselves as general practitioners) and another level for all other physicians. In the entire United States we are not aware of more than one instance in which different prevailing levels have been established between other types of specialists, such as pediatricians and internists. We would find it astounding if there are not many areas in which the prevailing charge level for a particular service provided by internists is not actually higher or lower than the prevailing charge level for that service when provided by pediatricians. We would be surprised if there are not many areas in which the prevailing level for a particular service provided by a pediatrician would not be different than the actual prevailing level for a group composed of all other physicians in the area.

I am not singling the internists and pediatricians out because I believe this is any more true for them than for any other types of specialists. The point is, we think it extremely likely that if any particular type of physicians were to be separated from another type of physician or all other physicians, and a prevailing charge level determined for each group, the prevailing level for one would be different than for the other. We ask why—if different prevailing levels must exist to preserve existing patterns of practice—no attention has been given to developing different prevailing levels for all types of specialists.

In opposition to the establishment of a single prevailing level for all types of physicians, we hear the statement that often an office visit to an internist—for example—is much more comprehensive than an office visit to a family physician and, therefore, they should not be subject to the same reimbursement limitations. This line of reasoning overlooks the fact that we are advocating a single prevailing fee for the same service or procedure. If two office visits are substantially different in scope, this should be recognized in the coding system which is used and there should be two levels of reimbursement for what, in effect, are two different services. However, the different reimbursement levels should be based on the fact that they are two different services rather than the fact that two different types of physicians are providing them.

In this regard, we believe relative value scales can be of use in serving as guidelines for the relative values of services and procedures. Although we do not advocate the use of relative value scales to establish what amounts to a fixed fee schedule, they have been developed after extensive study and do provide a wide breakdown of office procedures. As we mentioned above, we believe such a breakdown is necessary in order to appropriately recognize the different amount of time and skill devoted to procedures which may fall under the same general category, such as an office visit.

Before concluding my remarks, I briefly would like to touch on the issue of acceptance of assignment. It is our opinion that the decision on whether or not to accept assignment is based on two primary considerations. These are the amount of increased overhead which will result with the acceptance of assignment and the extent to which the amount actually charged exceeds the amount which the government will reimburse.

As to the first point, we believe that the greater number of claims which a physician must process, the less likely it is that he will accept assignment. Acceptance of assignment does result in increased overhead to the extent that additional office personnel is necessary to process the claims. This in turn may escalate the fee structure. To encourage acceptance of assignment, consideration should be given to accepting a statement from a physician's office providing required information, without additional transcription to a separate form.

As to the second point mentioned above, we think it is only logical to assume that as there is a decrease in the percentage of the physician's actual charge which will be paid by Medicare, there will be a decrease in the likelihood that the physician will accept assignment. Relative to this, there is a proposal currently before Congress which would require that in order for physicians to accept assignment, it would have to be accepted for all Medicare patients rather than on an individual basis. We do not believe this requirement will have the effect of increasing the number of physicians accepting assignment and oppose its enactment. Many physicians accept assignment on an individual basis because they know they have patients who could not otherwise afford needed medical care. However, there are many Medicare recipients who are financially well-off and for whom the physician does not agree to accept assignment. If the physician were to be required to accept assignment for these patients when his reimbursement will be substantially less than his usual charge and even though it easily could be paid by the patients, the result could well be that he would not accept assignment for any patients. This would have the opposite result of that intended by making it more difficult for those patients most in need of financial assistance to obtain medical care.

This concludes my statement. Thank you for giving us the opportunity to appear before you to present the views of the Academy. At this time, Dr. Hall and I will be happy to answer any questions which you might have.

Mr. BURLESON. Mr. Duncan.

Mr. DUNCAN. Thank you, Mr. Chairman.

I would like to thank the two gentlemen for their excellent presentation. You have always given us what I think is a physician's good sensible responsible medicine.

What are your thoughts on the family physician, I mean, family physician extenders or assistants in the program in the urban and rural areas?

Dr. BRUCKHEIM. I think it is wonderful to have a physician extender when you have a physician.

As you note, Mr. Duncan, there are many areas in your State where there are no physicians and we cannot replace the nonphysician by physician extenders.

You must get a physician into the area. Under those circumstances, I think physician extenders provide a valuable service and I think valuable services in many, many fields.

I would go along with the fact they can be reimbursed as long as they are under supervision. The essential factor is we don't have doctors in the area and to think by providing physician extenders to replace the essential of a physician in the area and get the same type of medical services is a fallacy.

Mr. DUNCAN. Do you think the physician ought to be present at all times?

Dr. BRUCKHEIM. No, sir, so long as a physician extender or "PA" is under his supervision, which can be telephone as well.

Mr. DUNCAN. Thank you very much and, thank you, Mr. Chairman.

Mr. BURLESON. Dr. Bruckheim, you, in mentioning the urban and smaller communities distribution of doctors' health care, particularly the family physician, evidently you won't quite agree with Mr. Morris who just appeared here before you, that the incentive to go into smaller communities or more rural areas, doctors, particularly those in general practice medicine, seem to feel there are several reasons why there is preference for the urban area practice.

Do you agree?

Dr. BRUCKHEIM. No, sir. I can't agree because of the statistics we have been able to develop in a short period of time concerning our residency programs.

Almost 70 percent of our residents go to populations of 35,000 or under and because of the methodology of training they are sent to the areas and gain insight into a total community's health problem.

That is family medicine. They thus become involved not in a single entity such as a myocardial infarction or heart attack, but that individual's work and become a part of the society and it is a rewarding type of medical practice.

I would say when we get doctors to practice in the area they tend to stay. They like it. Rural America is a wonderful place and when the doctors get there and find their position within society is met with the regard of their patients and with the regard of society and with the feeling of having a worthwhile job to do, then I think monetary things do become secondary.

Mr. BURLESON. That is definitely the impression I have from quite a few physicians who are my personal friends and I know that because of the smaller communities, because of family life, and the participating activities in the community and schools it is more personal and they like it.

I agree with you. I think so.

Dr. BRUCKHEIM. Yes, I do, I do think they do, but at the same time I don't think they ought to suffer a financial difference so large and so acute that the numbers between urban and rural form a dramatic difference.

If there are to be differences, and I don't believe in a difference, let them be minute and reasonable and valid, but at the present time they don't seem to be so.

Mr. BURLESON. Thank you very much.

If there is nothing further, thank you both for being here.

Dr. BRUCKHEIM. Thank you very much.

Mr. BURLESON. The next witness is the American Society of Anesthesiologists, Dr. John Ditzler.

We are glad to have you, Doctor, and you may proceed in your own way and summarize or read your statement, if you wish to.

STATEMENT OF JOHN W. DITZLER, M.D., PRESIDENT, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, ACCOMPANIED BY RICHARD AMENT, M.D., PRESIDENT-ELECT, AND MICHAEL SCOTT, COUNSEL

Dr. DITZLER. Thank you, Mr. Chairman.

I would like to introduce Dr. Richard Ament, a practicing physician from Buffalo, New York, president-elect of the American Society, and Mr. Michael Scott, legal counsel in the Washington law firm of Cox, Langford, and Brown.

Mr. BURLESON. Glad to have you.

Dr. DITZLER. My name is John W. Ditzler, M.D. I am a practicing anesthesiologist in Chicago, Ill. I am professor of anesthesiology at Northwestern University School of Medicine and in addition I am chief of staff of the Veterans' Administration Lakeside Hospital in Chicago.

My testimony is presented on behalf of the American Society of Anesthesiologists, an organization of physicians, of which I am currently the president.

I intend to testify today almost exclusively with reference only to one of the topics as to which the subcommittee seeks information and recommendations, that is, the role of relative value guides in determining physician fee reimbursement.

Before turning to that topic, however, I do want to point out that in testimony before the Senate Subcommittee on Health about 6 weeks ago, the society commented in some detail on those aspects of S. 3205, Senator Talmadge's bill, which appeared uniquely to deal with reimbursement for anesthesiology services.

I am submitting here today a copy of our statement before the Senate subcommittee, and as a preliminary matter, I would like to make a few brief comments on the subject of S. 3205.

Senator Talmadge's bill proposes that in order for professional anesthesia fees to qualify for reimbursement under medicare part B, an anesthesiologist must either have personally performed, or personally directed the performance of, anesthesia care services.

Our society unequivocally supports that basic principle. The bill also deals in some detail with the circumstances under which reimbursement may be made in the situation when an anesthesiologist personally directs others—nurse anesthetists, for example—in the performance of anesthesiology services.

While in our view optimum patient care will always involve personal performance by the anesthesiologist of anesthesia care services, we find ourselves generally in support of the reimbursement proposals of S. 3205, where only personal physician direction is involved.

We do believe that the bill goes too far in attempting to particularize reimbursement principles in cases of physician direction, believing as we do that these matters are better left to determination by the Bureau of Health Insurance rather than the Congress, but we have no major quarrel with the general intent of the bill in this respect.

We also support the concept of S. 3205 to the effect that physician effort as an administrator or researcher should not be compensated under part B, but we are critical of the sweeping prohibition of reimbursement under part B for physician's services as an educator.

There are many occasions when a physician is simultaneously performing a direct patient service and an educational function, as when he is personally directing the administration of an anesthetic by a resident, and we believe that reimbursement under part B in these instances is fully appropriate.

In general, we regard those portions of S. 3205 as dealing with anesthesiology to be thoughtful and reasonable, and with minor variations suggested in our testimony to the Senate subcommittee, we are not opposed to enactment of those portions into law as part of a general medicare-medicaid reform effort.

I turn now to my principal topic, the role of relative value guides in physician fee reimbursement.

The American Society of Anesthesiologists has for many years published a so-called "reative value guide." For those members of the subcommittee unfamiliar with such a document, let me explain that a relative value guide or scale purports to indicate—on the basis of complexity of a medical procedure, medical risks involved, time necessary to complete the procedure, and like factors—the relation of one procedure to another.

This is done by assigning each procedure a "unit value" which is meant to indicate in abstract, nonmonetary terms, the sum of considerations just mentioned.

Thus, for example, in our society's 1974 guide, anesthesia services for a tonsillectomy—without regard to the time required to perform the procedure or to special risk factors such as the age or general health of the patient—carries a unit value of five, whereas such services in connection with the amputation of a leg carries a unit value of three.

In short, in terms of just the complexity of and risks involved in the procedure from an anesthesia standpoint, the tonsillectomy anesthesia services are regarded as almost twice as medically complex or challenging as the amputation anesthesia services.

This result may surprise you in view of the comparative nature of surgical procedures being performed, but such a result is thoroughly consistent in my judgment with the relative skill required of the anesthesiologist and the anesthetic, as opposed to the surgical, risks involved in the two procedures.

I might parenthetically point out I noticed in your local papers yesterday a tragedy which only highlights there may be such things as minor surgical procedures but there is no minor anesthetic.

Let me emphasize that at least with reference to those guides published by our society and other guides and scales of which I am aware, neither the value of a medical procedure nor the value of a unit measure is stated in monetary terms.

The guide is not intended as a fee schedule and is not intended to suggest the relative value, or dollar amount, of the fee of any individual.

It represents only the judgment of those who have prepared the guide, based upon historical or other data as to the relationship between medical procedures under particular circumstances.

At this point I want to take note that the gentleman speaking in behalf of the National Blue Shield plans, near the conclusion of his testimony, indicates that the relative value guide is in effect nonetheless a fee schedule.

I would object on the grounds that it can only be a fee schedule if the third-party intermediary makes it so.

Relative value guides were by and large developed in response to requests by insurance companies and other third-party payers who were seeking some means by which to evaluate the reasonableness of individual physician charges for which the insurers were required to make payment or reimbursement.

Relative value guides provided a rational and understandable means of communicating with and responding to third parties in a manner which preserved the right of the individual practitioner to establish his own fees and the right of the particular payer to establish its own schedule of payment or reimbursement.

Neither the individual physician, nor the insurance carrier, was or is compelled to make use of the guide, and it simply represented—and in my judgment continues to represent—a useful tool for patient, physician and insurer alike to evaluate the reasonableness of a physician's proposed fee.

Last year the U.S. Department of Justice, apparently without previous consultation with the Department of Health, Education, and Welfare, brought suit against our society, charging that our preparation and dissemination of a relative value guide represented a per se violation of the Sherman Act, in that it represented a conspiratorial method for fixing the price of anesthesia services.

The society has filed its answer in the suit, denying any violation of the law, and the case now pends in the U.S. district court of the Southern District of New York.

We frankly expect to win that suit, although we recognize that it will be a long and punitively expensive process.

The society finds anomalous indeed that the Department of Justice has brought this suit, in view of the fact that another agency of the Federal Government, the Bureau of Health Insurance, in its instructions to intermediary carriers under medicare has specifically sanctioned the use of these guides, and in point of fact, has for many years both itself and through its intermediaries been a principal moving force in the development and refinement of these guides.

Indeed, where a relative value guide has been adopted by an intermediary as the basis for medicare reimbursement, physicians submitting claims are required to use the guide.

For the information of the subcommittee, the current BHI instructions to intermediaries concerning relative value guides, and specifically the guide of our society, are attached to our written statement before the Senate subcommittee being submitted with this statement.

As we noted in our testimony to the subcommittee, the society believes that relative value guides or scales are useful in the administration of medical care payment and reimbursement programs.

They are useful, however, only to the extent that they reflect the realities of medical practice and in this sense, they represent an opportunity for bonafide medical societies to articulate their views of those realities, in dealing with the Bureau of Health Insurance and its intermediaries.

We believe it to be both unfair and not in the national interest to preclude—as the U.S. Department of Justice would apparently do—anesthesiologists through our society or through State or local societies to offer their expressed opinions on the medical considerations necessarily involved in developing relative value guides or scales.

Because of this belief, our society has strongly supported the proposal of Senator Talmadge, introduced by the Senator as a working paper during hearings on S. 3205, to provide legislative validation to the use of relative value guides in connection with medicare or otherwise.

The working paper, a copy of which is submitted with our testimony today, essentially proposes that to assist BHI in determining and providing payment or reimbursement for physicians' services, BHI be authorized to use relative value guides or scales, to the extent it finds them reasonable, if such guides or scales are prepared by a bonafide professional society of physicians and covers medical procedures of the type normally performed by members of that society.

The working paper states that the preparation, dissemination and use of such a guide shall not in itself be deemed a violation of the antitrust laws, and makes clear that no person, including BHI, is compelled to use the guide should he not wish to do so.

We think the Senator's proposal represents a highly intelligent approach to the problem. Development and dissemination of the guides are authorized, but no one is compelled to use them.

Development and dissemination of the guides are stated to be, in and of themselves, not violations of the antitrust laws.

This language leaves open the possibility that misuse of the guides, for example, collusive price-fixing based thereon, would still be actionable under the antitrust laws.

Most important, from our point of view, the proposal would lend legislative blessing to the right and privilege of organized medicine to participate in, and express its views on, the continuing development of a framework against which reasonableness of individual fees may be measured for reimbursement purposes.

As some members of the subcommittee may be aware, the Federal Trade Commission has recently taken action against at least three other medical societies with reference to their promulgation of relative value guides.

During testimony before the Talmadge subcommittee, one of those other societies, the American College of Radiology proposed a similar legislative validation of relative value guides, and for the information of the subcommittee and its staff, we are attaching to this statement the radiologists' proposal and their testimony in relation thereto before the Talmadge subcommittee.

We are aware that the principal concern of this subcommittee, as well as the Talmadge subcommittee, relates to the rapidly escalating costs of medical services, including physicians' services, under medicare and medicaid.

It is my personal belief, shared by many other members of our society, that utilization of a relative value guide, as a frame of reference against which the Bureau of Health Insurance and its intermediaries can evaluate individual physician charges, has had and will continue to have the effect of restraining the rising cost of medical services, rather than provide a mechanism for increasing those costs.

Given the inelastic demand for medical services, and anesthesiology services in particular, the sole practical major restraint upon escalating physicians' fees under medicare and medicaid is, quite bluntly, an informed and aggressive posture by the Bureau of Health Insurance and its intermediaries.

We believe that the availability to BHI and its intermediaries of a responsibly developed relative value guide prepared by a particular medical specialty organization, which these agencies are free to use or not as they choose, represents a valuable tool in the hands of the Government for evaluating the reasonableness of physician fees, while at the same time permitting organized medicine to offer its views as to the basis on which that reasonableness may be measured.

We thus urge that this subcommittee give detailed consideration to Senator Talmadge's working draft, and to other responsible proposals for legislative validation of relative value guides.

My colleagues and I will be pleased to respond to your questions and I thank you for your attention.

Mr. ROSTENKOWSKI [presiding]. Mr. Duncan.

Mr. DUNCAN. I don't believe I have questions.

Mr. ROSTENKOWSKI. Mr. Burleson?

Mr. BURLESON. No questions.

Mr. ROSTENKOWSKI. We thank you very much.

The attachments to your statement will be made a part of our record.

[Attachments to the prepared statement follow:]

STATEMENT OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

SUMMARY

1. The use of the term "hospital associated physicians" in Section 22 is misleading and should be changed.
2. Optimum anesthesia care involves a one-on-one relationship between anesthesiologist and patient. Anesthesiologist manpower limitations may, however, necessitate patient care in less than optimum conditions, in which event ethical principles require that medical direction of non-physician providers be given.
3. While raising certain negative implications concerning right to reimbursement for legitimate anesthesiologist services, Section 22 as it relates to anesthesiology is generally in accord with the Society's ethical guidelines.
4. Prohibition in Section 26 against use of certain percentage of collection billing practices, through use of independent billing organizations, is too broadly stated.
5. Proposed validation of dissemination and use of professionally-developed relative value guides is entirely meritorious and in the interest of all concerned with Government-financed medical insurance.

STATEMENT

My name is John W. Ditzler, M.D. I am a practicing anesthesiologist in Chicago, Illinois. I am a Professor of Anesthesiology at Northwestern University School of Medicine and in addition am Chief of Staff of the Veterans Administration Lakeside Hospital in Chicago.

I testify today on behalf of the American Society of Anesthesiologists, an organization of physicians of which I am the current President. My testimony represents the position of the Society, approved in principle by our Administrative Council, on those issues raised by S. 3205 which are of particular interest to the Society and its members. With minor exception, I do not intend to deal with those aspects of S. 3205 which concern organized medicine generally, as I anticipate that these subjects will be covered by testimony of the American Medical Association and others.

The membership of ASA consists of over ten thousand licensed physicians engaged in the recognized specialty practice of anesthesiology. While, as is commonly understood, anesthesiologists are principally concerned with the administration of anesthetic agents as a part of surgical or obstetrical procedures, they also engage in an increasing variety of related medical activities, particularly including pain therapy, respiratory therapy, and intensive care. We are indeed today witnessing the development, within anesthesiology, of various subspecialties; a development which I fully endorse in light of the increasing complexity of our profession.

In S. 3205, anesthesiologists are referred to as "hospital associated" physicians—essentially, I assume, because most of the medical services of anesthesiologists are performed within the physical confines of a hospital. Unfortunately, however, this term carries with it another connotation or implication, that is, that anesthesiologists are in some form of employment or agency relationship with the hospital. This implication is misleading: with only minor percentage exception, anesthesiologists perform their services as independent medical professionals, and are compensated for these services on the basis of a fee charged to the individual patient. They are no more "hospital associated"—or to use another misleading expression: "hospital-based"—than for example are the surgeons or obstetricians who form a part of the medical care team with which the anesthesiologist is most frequently involved. If then the Subcommittee finds it necessary to refer generically to certain medical specialties practiced in the hospital setting, the Society believes it far more appropriate, and not misleading, to use the expression: "certain physicians' services normally performed in a hospital."

The Subcommittee may well wonder why I choose, in testimony with respect to an important piece of proposed substantive legislation, to pause at the outset over what appears to be a minor definitional problem. To the members of our Society, the answer is quite simple: use of the terms "hospital-based" or "hospital associated" in relation to anesthesiologists, and for that matter, pathologists, radiologists and others, connotes that somehow these specialists are less independent than, or somehow different from, other independent professional specialists who perform in a hospital setting but as to whom, for reasons not clear, the terms are never employed.

This differentiation causes the average anesthesiologist to see "red". Anesthesiology has emerged in the past three decades as a recognized and vitally important field of independent medical specialization and practice. Many operative procedures performed in 1976, that could not have been performed in 1956 or 1966, are possible not so much because of new surgical techniques, but because of the enormous strides which have been made in the science and art of anesthesiology. Our members are proud of these accomplishments and of their independent status in the profession and in relation to the individual patient. They are thus sensitive to any legislative appellation which tends to derogate from this independent status.

As the Subcommittee is aware, S. 3205 contains certain express provisions relating to reimbursement under Part B for anesthesiology services. Your Chairman has already indicated, upon introducing the Bill, that these provisions were prepared after consultation with representatives of our specialty. Quite frankly, valuable communication between the Subcommittee and its staff, on the one hand, and practicing anesthesiologists on the other hand, was possible because many of the so-called "abuses" under Medicare, with which Senator Talmadge is concerned as an economic or social matter, are practices with which, to the extent they may exist, our Society should also be concerned as an ethical matter. Specifically, it is the formal position of the Society that anesthesia care of a patient should ethically be performed either by, or under the actual direction of, an anesthesiologist, and that compensation for anesthesia care under these circumstances should ethically be on a fee-for-service basis to the patient. As we view the provisions of S. 3205 dealing specifically with anesthesiology services under Medicare, they are fundamentally consistent with these ethical principles.

Before discussing these provisions in some greater detail, I should like to make two points. While we as a Society have strong views as to what is, and what is not, ethical as a professional medical matter for anesthesiologists, we do not suggest that these ethical guidelines are necessarily applicable across the medical profession as to other specialties. When thus we state that patient anesthesia care services may ethically be performed only by or under the actual direction of an anesthesiologist, we do not claim that these ethical guidelines are necessarily required elsewhere in the profession. I speak for anesthesiology today, for anesthesiology only.

My second point is that without qualification, optimum anesthesia care involves a one-to-one relationship between anesthesiologist and patient. While both the ASA ethical guidelines and Section 22 of the Bill clearly contemplate the possibility for medical direction by the anesthesiologist of nurse anesthetists or other non-physician members of the anesthesia care team, we do not as a Society believe that there is any medical substitute for the one-on-one relationship. Personal physician direction of others may in many circumstances be medically acceptable, but in our view only personal performance represents the optimum.

Section 22 of the Bill contains the essential requirement of either personal performance or personal direction by a physician, in order to qualify for reimbursement under Part B, and insofar as that requirement relates to anesthesiology, we support it with the qualification just stated. We also support the concept contained in the Bill that "physicians' services", reimbursable on a fee-for-service basis, do not include work as an executive or a researcher. We are, however, concerned by the apparent general disqualification in Section 22 of services as an "educator" from reimbursement on a fee-for-service basis. An anesthesiologist, during the course of rendition of an identifiable patient service, may very well be engaged, simultaneously, in an education function with respect to, for example, a resident physician also present in the operating suite. It seems unrealistic to attempt to separate out this educational function from the physician service being rendered, appropriately, to the patient on a fee-for-service basis.

We agree, as an ethical matter, that physician reimbursement arrangements, based upon a percentage of hospital income or receipts, are inappropriate. In general, we are also supportive of the provisions of Section 22 dealing particularly with reimbursement for anesthesiology services, although we have certain specific suggestions for clarifying or improving these provisions.

As to anesthesiology services, Section 22 sets forth certain criteria on the basis of which, for reimbursement purposes, an anesthesiologist is deemed to have "personally performed", or "personally directed" the rendition of, such services. These criteria are determined by reference to a statement, set forth in the Bill, of the various steps which normally comprise the totality of anesthesia care rendered to a patient—from pre-anesthetic evaluation, through the administration of the anesthetic, to the rendition of indicated post-anesthesia care. The enumerated steps are drawn from ASA's 1975 Guidelines for Ethical Practice.

While we are gratified by the inclusion of our ethical guidelines in the Bill, we are at the same time concerned about the potential rigidity inherent in the specification, in a Federal statute, of those individual items of anesthesia care which will form the basis for reimbursement unless and until the statute is amended. The science of anesthesiology is evolutionary, in terms of development of new techniques, and individualistic, in terms of patient need. As a result, ASA would strongly have preferred that the Bill confine itself to statement of principle concerning personal performance and personal direction of anesthesia care, and left to the Bureau of Health Insurance the enumeration of acts, or combination of acts, which would provide basis for reimbursement. Our experience is that while always difficult, the amendment of Medicare regulations is far easier to accomplish than amendment of a Medicare statute.

We are also concerned by certain negative implications created by the wholesale inclusion of the ASA ethical principles in the Bill. There are many valuable and important medical services performed or directed by an anesthesiologist that are not explicitly or implicitly covered by the Bills' statement of anesthesia care services. Two of the fastest-developing areas of anesthesia care are in the fields of pain therapy and respiratory therapy. The services comprising these courses of patient care simply do not follow the pattern of anesthesia care related to the operating or obstetrical suite. Yet the Bill as worded implies, unintentionally I am certain, that these important services are not reimbursable under Part B. Again, I believe, appropriate forms of reimbursement mechanism for these services are best established by regulation, rather than statute.

If the Subcommittee determines, despite the problems that I have suggested, to attempt legislatively to deal with the details of anesthesia services under Part B, then at the least I believe that the language and intent of Section 22 must be clarified. Attached to my statement is a suggested revision of Section 22—insofar as it specifically covers anesthesia care—which makes more clear that legitimate anesthesiology services continue to be covered under Part B, notwithstanding the fact that they are not among those services, or combinations of services, expressly referred to in Section 22.

In closing my discussion on Section 22, I should like to come back in part to a point I made earlier: medically, the one-on-one relationship between anesthesiologist and patient is the optimum. Section 22 contemplates reimbursement of an anesthesiologist when he medically directs up to four nurse anesthetists or other non-physicians simultaneously. In my view, this limitation has two faces: on the one hand, the limitation goes far to prevent the purported exploitation of nurse anesthetists with which the American Association of Nurse Anesthetists appears to be in some cases legitimately concerned; on the other hand, I wish to make clear that in my view, it is only under certain narrow circumstances that an anesthesiologist can properly direct four procedures simultaneously. Many respected anesthesiologists, while recognizing the one-on-one patient relationship as the optimum, will also say that the medical direction of two, or perhaps three, highly skilled nurse anesthetists simultaneously is the maximum reasonably possible from a medical point of view. In this sense, we find that the Bill's limitation of four to be somewhat liberal, but appropriate when as is necessary in legislation, coverage of generalized circumstances is required.

I should say at this point that in preparing for this presentation, I caused summaries of S. 3205, prepared by our counsel, to be circulated widely within our membership. As you might anticipate, the Bill received extensive comment by a number of practicing anesthesiologists. While most of this comment related to the subjects I have already discussed, I would be remiss in my responsibility if I did not cover one additional point which received substantial attention: specifically, concern has been expressed that the proposed prohibition contained in Section 26 against assignment of Medicare and Medicaid fees under a power of attorney may tend to throw out the baby with the bathwater.

In our experience, many anesthesiologists in various parts of the country—and particularly those who practice individually or in very small groups—find that the least expensive and only practical method of billing for their services—whether to a private or a Medicare patient—is under a contractual arrangement with an independent billing organiation. Many of these organizations do tend to operate on an across-the-board percentage of collection basis, and some of our members doubt strongly that if this percentage basis were eliminated (as the Bill proposes to do) for reimbursement purposes, Medicare and Medicaid costs would be lessened. It would seem to us that much of the potential adverse effect, apparently of concern to the Subcommittee staff, would be eliminated if another exception to the general rule, contained in proposed Section 26, were made for the use of a billing service organization on a percentage of collection basis, when a physician used that service organization for all his services to patients, and not just for Medicare or Medicaid patients (or Government reimbursement with respect thereto). This exception would, I believe, tend to legitimalize the true and comprehensive billing service, while at the same time substantially eliminating the potential for abuse in the factoring of Medicare and Medicaid claims.

Finally, I turn to a subject only tangentially related to S. 3205, but nonetheless one of major importance to our Society. Specifically, we have noted with obvious interest your Chairman's proposal to include in the legislation being considered a provision which would give statutory sanction, in a limited context, to the use of relative value scales. I say "obvious" because it is well known that despite the fact that the Department of Health, Education and Welfare has encouraged the formulation of such scales and in fact depends upon such scales in administering the Medicare Program, another executive department (the Department of Justice) has sued our Society for its adoption and publication of a relative value guide. It seems entirely appropriate for Congress to resolve this administrative ambivalence.

Because of the multiplicity of factors which an individual anesthesiologist considers in determining his fee for particular services, health insurance carriers and various governmental agencies involved in paying or reimbursing for anesthesiologists' fees have historically had considerable difficulty in formulating fair, reasonable and administratively feasible methods of payment and reimbursement, consistent with applicable statutory and regulatory requirements yet related to the specialty's mode of practice. Many insurance carriers and governmental agencies, including the Bureau of Health Insurance and its intermediaries, have found relative value guides, including our Society's Relative Value Guide, a reasonable solution to the problems of constructing rational and workable payment and reimbursement schedules and resolving disputes as to particular claims. The policy of the Bureau of Health Insurance as to the use of relative value scales generally, and the ASA Relative Value Guide in particular, is stated in an August 1975 revision to its "Part B Intermediary Manual," a copy of the pertinent portions of which is attached to my written statement.

In formulating and publishing its Relative Value Guide, the ASA has sought to respond to the needs of their third party payers, including Medicare intermediaries, in a manner which preserves the right of the individual practitioner to establish his own fees and the right of the particular payer to establish its own schedule of payment or reimbursement. Only the prevailing expert medical opinion as to the relationship between medical procedures in terms of relative complexity, time or effort necessary for completion and other relevant medical considerations is reflected in the Guide. No dollar amount of fees or conversion factors are specified. Indeed, except as an individual practitioner may be require by third party payer regulations, no one is under any compulsion to use the Guide itself.

We believe that relative value scales or guides are useful in the administration of health care payment and reimbursement programs. They are useful, however, only to the extent that they reflect the realities of medical practice. Certainly bona fide associations such as ASA should not be precluded from offering their expert opinions on the medical considerations involved in developing relative value scales and guides.

We thus strongly support the proposal of your Chairman, which we understand was presented to the Subcommittee at the outset of these hearings, to provide legislative validation to the use of relative value scales in connection with Medicare and otherwise. We believe this to be an intelligent and practical approach, of benefit alike to the medical profession, medical insurance intermediaries, the Government and the patient.

PROPOSED AMENDED SECTION 22, S. 3205

SEC. 22. (a)(1) Section 1861(q) of the Social Security Act is amended by adding "(1)" immediately after "(q)" and by adding, immediately before the period at the end thereof, the following: "; except that such term does not include any service that a physician may perform as an [educator,] an executive or a researcher; *or as an educator when such educational function is not performed simultaneously and in connection with the personal performance or personal direction of an identifiable patient care service*; or any patient care service unless such service (A) is personally performed by or personally directed by a physician (*or, in the case of physicians associated in physician group practice, by one or more physician members of the group*) *for the benefit of* such patient and (B) is of such a nature that its performance by a physician is customary and appropriate."

(2) Section 1861(q) is further amended by adding the following new paragraphs at the end thereof:

"(2) In the case of anesthesiology services, a procedure *related to surgical or obstetrical care of a patient* would be considered to be 'personally performed' in its entirety by a physician [only], where the physician performs *for the benefit of one individual patient* the following activities:

"(A) preanesthetic evaluation of the patient;

"(B) prescription of the anesthesia plan;

"(C) personal participation in the most demanding procedures in this plan, including those of induction and emergency;

"(D) following the course of anesthesia administration at frequent intervals;

"(E) remaining physically available for the immediate diagnosis and treatment of emergencies; and

"(F) providing indicated postanesthesia care:

Notwithstanding the foregoing, a physician shall also be considered to have "personally performed" such a procedure in its entirety for an individual patient if [provided, however, that] during the performance of the activities described in subparagraphs (C), (D) and (E), such physician is [not] responsible for the care of *not* more than one other patient. Where a physician performs the activities described in subparagraphs (A), (B), (D), and (E) and another individual participates in the activities described in subparagraph (C), such physician will be deemed to have personally directed the services if he was responsible for no more than four patients while performing the activities described in subparagraphs (D) and (E) and the reasonable charge for such personal direction shall not exceed one-half the amount that would have been payable if he had personally performed the procedure in its entirety.

In the event a physician or group of physicians associated in group practice personally performs or personally directs performance of anesthesiology services for the benefit of a patient, the reasonable charge for which has not been expressly provided for in this paragraph (including without limitation personal performance or direction of one or more of the individual activities enumerated above relating to surgical or obstetrical care or personal performance or direction of the rendition of pain therapy, respiratory therapy, intensive patient care, such physician or group shall be entitled to payment of a reasonable charge for such physicians' services which charge shall be fairly related to the reasonable charges expressly provided for in this paragraph.

REASONABLE CHARGES—CRITERIA, AUGUST 1975

6707.1 *Use of Relative Value Scale and Conversion Factors.*—The use of relative value scales in estimating customary charges and prevailing charges should be restricted to situations in which the carrier does not have sufficient data or to procedures that are performed only infrequently. In addition, the relative value scales used for the Medicare program should, to the extent possible, be those that are used by the carrier in its own programs. Relative value scales developed by the carrier or by medical societies for States other than those in which the carrier's Medicare service area is located should be carefully reviewed and validated before they are used. The carrier has a responsibility for ensuring that a relative value scale, which is used to estimate customary charges or prevailing charges, accurately reflects charge patterns in the areas serviced by the carrier. Similarly, the conversion factor used with the relative value scale should reflect the known customary charges of the physician or other person for whom a customary charge is being estimated, or the known prevailing charges for services in the locality, as appropriate.

Customary and/or prevailing charge conversion factors used with relative value scales to fill gaps in carrier reasonable charge screens should be calculated as outlined in A and B below.

(Separate customary charge conversion factors should be developed for each physician or supplier from his known customary charges in the same category of service, e.g., medicine, surgery, radiology, etc. Similarly, separate prevailing charge conversion factors, by locality and specialty or groups of specialties, should be calculated based on the known prevailing charges, by locality and specialty, or groups of specialties within the same category of service.)

A. *Customary charge.*—The following formula should be used for the calculation of a customary charge conversion factor:

C/F=Customary charge conversion factor.
CHG=The physician's customary charge for a procedure.
SVC=Number of times the physician performed the procedured.
1^{-n}=The different procedures the physician performed within a category of service.
RVU=The relative value unit assigned to a procedure.

Σ=Sum of

$$C/F=\frac{\frac{CHG_1}{RVU_1}\times SVC_1+\frac{CHG_2}{RVU_2}\times SVC_2\cdots\frac{CHG_n}{RVU_n}\times SVC_n}{\Sigma SVC_{1-n}}$$

Example: Compute a customary charge conversion factor for a physician with the following charge history: (May be for medicine, surgery, radiology, pathology)

	Frequency	Customary charge	Relative value
Procedure:			
1	3	$5	1.0
2	7	12	2.0
3	5	35	4.0
4	4	20	3.0
5	6	8	1.5
Total	25		

Method:

1. For each procedure, divide the customary charge by the relative value and multiply the result by the frequency of that procedure in the physician's charge history.
2. Add all the results of these computations.
3. Divide the result by the sum of all the frequencies.

Solution:

$$\frac{\left(\frac{5}{1}\times 3\right)+\left(\frac{12}{2}\times 7\right)+\left(\frac{35}{4}\times 5\right)+\left(\frac{20}{3}\times 4\right)+\left(\frac{8}{1.5}\times 6\right)}{25}$$

$$=\frac{(5\times 3)+(6\times 7)+(8.75\times 5)+(6.67\times 4)+(5.33\times 6)}{25}$$

$$=\frac{15+42+43.75+26.68+31.98}{25}=\frac{159.41}{25}$$

$$=\$6.38=\$6.40 \text{ (Rounded to nearest 10 cents)}$$

To determine a physician's customary charge for a particular procedure where there is no reliable statistical basis, multiply the relative value of the procedure by the physician's customary charge conversion factor for the appropriate category of service (e.g., radiology, medicine, surgery).

B. *Prevailing charges.*—The prevailing charge conversion factors to be used with the appropriate relative value scale will be developed from the same formula used for customary charge conversion factors, *except that*

CHG=The established prevailing charge for a procedure by locality and specialty or group of specialties

SVC=The number of times the procedure was performed by all physicians in the sample specialty or group of specialties and locality

1^{-n}=The different procedures within a category of service for which prevailing charges have been established by specialty or group of specialties and locality

The conversion factors calculated for any fiscal year should reflect customary and prevailing charges calculated on the basis of charge data for the preceding calendar year. Also, reasonable charges established through the use of a relative value scale and conversion factors, in effect, consist of two components. Consequently, the conversion factors used must be recalculated when there is any change in the relative value units assigned to procedures (as may occur if the carrier begins to use a different or updated relative value scale) in order to assure that the change(s) in unit values do not violate the integrity of the reasonable charge screens.

Reasonable Charges—Special Situations and Instructions, August 1975

6818. *Reasonable charges for anesthesiologists' services.*—

The manner in which a carrier applies the reasonable charge criteria in processing claims for anesthesiologists' services should be consistent with the predominant billing methods of such physicians in its service area.

For example, where the majority of anesthesiologists bill dollar amounts for services without any indication of the relative value units associated with their services, the carrier should establish customary and prevailing charge screens for such services in the same manner as for other physicians. This approach to determining reasonable charges takes into account the fact that a physician's charges for a particular service may, for a variety of reasons, vary from one instance to another. Therefore, under this approach, any extra amounts charged by a physician using a relative value scale and a dollar conversion factor to set his fee (e.g., the time, risk, age, etc.) will not ordinarily be a basis for allowing amounts above the applicable customary or prevailing charge. However, the provision in the regular Medicare reasonable charge methodology for allowing higher amounts when they are justified by unusual circumstances or medical complications (§ 6708) does apply in appropriate instances.

However, in many parts of the country, carriers have adopted the use of relative value scales and conversion factors in establishing reasonable charge screens for anesthesiologists' services as an accommodation to such physician's traditional use of this methodology in setting their fees and in billing for services.

The American Society of Anesthesiologists and many State medical societies have developed relative value guides from which an anesthesiologist may determine his fee for a given service. These guides generally assign base unit values to the different surgical procedures and services listed and provide for additional units taking into account such factors as time, risk, age of the patient etc. Each anesthesiologist may apply a dollar conversion factor that he has set for himself or he may use a conversion factor that his local medical society considers to be reasonable. Where (1) this is the predominant billing practice among the anesthesiologists in a carrier's service area, and (2) where their billings include the necessary information about the unit values they have used in setting their fees for a particular service, the carrier should take this practice into account in establishing reasonable charge screens. It should, based on actual charge data, establish a customary charge conversion factor for each anesthesiologist and, from all such conversion factors, develop a prevailing charge conversion factor using the following suggested approach. (Deviations from this suggested approach must have prior BHI approval.)

A. Establish the conversion factor the anesthesiologist has used in each billing during the year. For example, where the physician has billed $54 for an anesthesia service and the total of the relative value units for the service rendered (base, time, and other modifier) was 9, he has in effect used a $6 conversion factor.

B. Determine the anesthesiologist's customary charge conversion factor by determining the median of the conversion factors he has billed during the year. (Where the actual median falls between two items in the array of conversion factors, use the next highest conversion factor in the array.) For example:

	Billed charge	Total relative value units (time, base, other modifiers)	Conversion factor
Procedure:			
A	$120	20	$6
B	72	12	6
B	60	10	6
C	48	8	6
D	84	14	6
E	150	25	6
A	140	20	7
B	77	11	7
D	120	15	8
D	96	12	8
D	104	13	8
E	176	22	8

In the above example, the actual median of the conversion factors would fall between $6 and $7. Therefore, the customary charge conversion factor is $7. A prevailing charge conversion factor should also be computed for anesthesia for each locality, by specialty, by arraying the anesthesia customary charge conversion factors in ascending order and weighing each by the frequency of services on which it was based. An actual amount in the array which is high enough to include the customary charge conversion factors of the anesthesiologists who performed at least 75 percent of the cumulative services should then be identified as the prevailing charge conversion factor.

The conversion factors calculated for any fiscal year should reflect the charges made by the anesthesiologist(s) during the preceding calendar year. Also, the conversion factors must be recalculated where there is a change in the number of relative value units assigned to procedures or to modifying factors such as time, age, risk, etc., (as may occur if the carrier begins to use a different or updated relative value scale). This is necessary to assure that the carrier's reasonable charge screens are unaffected by such a change.

TESTIMONY ON S. 3205, SENATE FINANCE COMMITTEE, SUBCOMMITTEE ON HEALTH, JULY 28, 1976

(The American College of Radiology, John M. Dennis, M.D., President, Fredric D. Lake, M.D., Chairman, Board of Chancellors)

A second general point deals with a need for relief from a situation in which efforts to be responsive to some federal agencies place use in jeopardy with others. We are encouraged to raise this by the chairman's inclusion of it in his speech to us. Our specific reference is to current efforts of the Department of Justice and the Federal Trade Commission to impute that the contrivance and distribution of standard terminologies and relative value scales by medical groups represent violations of anti-trust laws.

The College's first relative value scale was prepared in specific response to a request from the CHAMPUS program during the 1950s. It has been welcomed enthusiastically in its several versions by third party carriers and by the federal agencies charged with administering Title 18 and Title 19 health benefit programs. Such information may be used to develop a fee schedule by individual physicians, by hospitals or by health insurance carriers. Indeed, some such exercise must be undertaken by anyone with a need to develop a fee schedule or profile.

But to take the position asserted by the FTC that the preparation and distributon of a relative value schedule or scale with appropriate disclaimers by a medical group is a per se violation would make it impossible for such professional societies to offer cooperation to federal health agencies and could perhaps make it difficult for us to assist committees of the Congress by gathering and providing information about our specialties and practices.

We urge stongly that the subcommittee consider adding language which would amount to a limited anti-trust exemption for medical societies which have created these nomenclatures, coded terminologies and relative value scales. We do not suggest that medical societies be immunized against penalties for misuse of such materials. Rather, we request that your language require that an organization which has prepared a relative value scale be proven to have misused it to restrain trade. In this fashion, badly needed relief could be granted without opening a much broader issue of anti-trust law. We offer as an attachment to this testimony possible language for a section to accomplish this limited exemption.

LIMITED ANTITRUST EXEMPTION

Section 1—Policy

In the public interest of enabling physicians to establish charges for medical services which have a reasonable relationship to the comparative difficulty, risk and degree of skill required by such services, and to enable federal and state health agencies, fiscal intermediaries and insurance companies to estimate realistically the costs of health care delivery and to determine the reasonableness of particular charges for medical services, it is hereby declared to be the public policy of the United States to permit individual physicians or representative groups of physicians to study, establish or revise codes, indices, standard terminologies and relative value scales for particular medical services.

Section 2—Definitions

1. The term "anti-trust laws" means the Federal Trade Commission act and each statute defined by section 44 of title 15 of the United States Code as "anti-trust laws" and all amendments to such acts and to such statutes and to any other acts in pari materia.

2. The term "representative group of physicians" means a state, regional or national association of physicians described in section 501(c)(3 or (c)(6) of the Internal Revenue Code.

3. It shall not be unlawful under any anti-trust laws for any person or representative group of physicians to create, publish or revise any code, index, standard terminology or relative value scale for particular medical services if such code, index, standard terminology or relative value scale reasonably relates the comparative difficulty, risk and the degree of skill required in rendering such medical services.

Mr. ROSTENKOWSKI. Dr. Luibel and Mr. Perrin.

Gentlemen, will you identify yourselves and proceed with your testimony.

STATEMENT OF GEORGE J. LUIBEL, D.O., PRESIDENT, AMERICAN OSTEOPATHIC ASSOCIATION, ACCOMPANIED BY JOHN P. PERRIN, DIRECTOR, WASHINGTON OFFICE

Dr. LUIBEL. Mr. Chairman and members of the committee, I am George J. Luibel, D.O., of Fort Worth, Tex., and I am president of the American Osteopathic Association.

With me is Mr. John P. Perrin, director of the AOA Washington office.

We are most pleased to have the opportunity to present the views of the American Osteopathic Association on the subject of medicare reform.

Mr. Chairman, we have a written statement which, with your permission, I will offer for the record, however, I will in my oral statement touch on some of the more important parts and important points raised in our full statement.

Mr. ROSTENKOWSKI. Your entire statement will be included in the record, Dr. Luibel.

Dr. LUIBEL. The first issue, and that from which the others follow, relates to the factors influencing the physician in his decision to accept or refuse to accept assignments.

Our belief is that there are four principal factors, any one of which may precipitate a decision on the part of the practitioner to refuse assignment.

First, in virtually all cases, the level of reimbursement through assignment represents a substantial "discount" of the physician's customary fee for the service rendered.

Thus, a physician having a significant number of patients covered by medicare may make his decision on a purely economic basis.

A second factor contributing to a decision to refuse assignment is the actual reimbursement timeframe. Government payment of assigned claims is, very often, inexcusably slow.

A further deterrent is the additional paperwork required in processing assigned claims. The administrative burden occasioned by such claims processing has necessitated more clerical support in physicians' offices and has, to some extent, in effect, robbed the physician of practice time.

Lastly, we believe it is fair to say that some of the resistance to the acceptance of assignments is predicated on a generalized repugnance for third-party medicine and government intrusion in particular.

It follows that inducements toward broader acceptance of assignments would be: more realistic reimbursement levels, faster claims processing and a reduction of the "redtape". If improvement in those three areas occurred, some of the generalized disaffection might also disappear.

With respect to the desirability or "necessity" of requiring acceptance in all cases, it is our view that the result might be the opposite of that which would be intended.

Given the continued presence of the dissuaders referred to earlier, many physicians confronted with such a choice might well elect to reject all assignments. We would hope that broader acceptance will be won and not forced.

With reference to the subject of differentials in reasonable charge levels, between urban and rural practice areas, and the implications of such differences on efforts to attract physicians to medically underserved rural areas, it is virtually axiomatic that the unfavorable economic comparison will act as a powerful deterrent.

As you know, this association is most sensitive to the need for such increased numbers of general practitioners and the acute need for such physicians in many rural areas.

We are continuing to produce an exceptionally high percentage of primary care physicians. While our educational process develops a physician highly motivated toward direct patient care, his choise of practice setting will still be influenced by economic realities.

Even allowing for lower overhead and general cost of living in rural areas present differentials in allowable charges discriminate against the rural practitioner.

Next, the matter of reasonable charge differentials between primary care physicians and other physicians has been of concern for some time.

It seems most anomalous that the Federal Government should be pressing hard for more primary care physicians with one hand and paying other physicians appreciably higher medicare fees for a given service with the other.

It is hard for us to understand such duplicity, and it is difficult to rationalize to students on the threshold of making postgraduate training decisions.

If a subspecialist receives more than a general physician for the same medical service, then we will continue to have more subspecialists than general physicians.

As to the feasibility and desirability of reimbursing on a fee schedule rather than on customary and prevailing charges, it is our view that to do so might well exacerbate existing reimbursement discriminations and relative inflexibility.

Unless a fee schedule could be developed, in consultation with the local medical community, for every local area in the country then the changes of achieving equitable reimbursement would be negligible; and unless all such schedules were reviewed, on at least an annual basis, then they would likewise tend to produce an unfair reimbursement result.

In regard to the legislation which has been introduced related to medicare reform, we would offer some observations on S. 3205 and H.R. 13080.

First, with reference to section 20, we understand the subcommittee's attempt to entice new physicians to enter manpower shortage areas.

Allowing such doctors to establish their customary charges at the 75th percentile, rather than at the 50th percentile, as presently drawn, would be a potent incentive, but it could occasion some harsh results by discriminating against physicians already practicing in the medically underserved community.

We are also concerned that the proposed use of statewide prevailing charges, in addition to the locally prevailing charges, might widen the payment discrepancies among the localities instead of closing the gap as intended.

Another provision would categorize physicians as either "participating" or "nonparticipating" under the medicare program.

A participating physician is defined, in the bill, as an M.D. or D.O. who voluntarily and by formal agreement assents to accept the reasonable charge determination on an assignment basis, as the full billing amount for all services to all medicare patients.

These agreements could be terminated on 30-days' notice. To encourage physicians to participate in the program, several inducements have been offered; they are as follows:

1. Physicians would be remitted an extra $1 on all eligible patient claims as an "administrative cost-saving allowance."

2. Not less than 50 percent of the estimated allowable payment would be remitted with 5 working days.

3. All claims can be submitted on a simplified, multiple listing basis rather than submitting individual claim forms.

As we have said earlier, it is unfortunate that the existing reimbursement structure and the immense paperwork demanded has deterred physicians from participation in the program.

Accordingly, we praise the sponsors for their willingness to experiment with such an incentive approach. We feel, however, that whether or not this incentive program achieves its goals, the "multiple listing claim sheet" concept should be incorporated into the administrative mechanisms of the medicare-medicaid program immediately.

Finally, section 22, relating to "hospital-associated physicians" would place narrow definition on those services performed by anesthesiologists and pathologists to be classified as "physician services".

In addition, ceilings would be established on the amount paid to physicians were related to hospital income. The new language would specifically exclude from the definition of "physician services" those professional services performed as an educator, an administrator or a researcher.

We do not feel that the definition of a physician's service as being only those where he is directly treating a patient or performing duties that only a physician can perform is reasonable or fair to those doctors whose activities whether they are administrative or educational, bear directly on the quality of care rendered by the providing institution.

In addition to the question of equity, it may well be unwise to take such drastic action as a cost-saving tactic when it could potentially adversely affect the number of medical school graduates desiring to enter such specialties.

The number of pathology residents in osteopathic hospitals has declined over the past 5 years. Enactment of section 22, as presently drawn, could well accentuate this shortage and jeopardize the quality of institutional care delivered.

Mr. Chairman, we again thank you for the opportunity to testify on the important issue of medicare reimbursement reform and pledge our continued cooperation in finding ways to improve the system to the satisfaction of the patient who is our primary care, the government, and the physician.

We would be happy to respond to any questions you or the Members may have.

Mr. Rostenkowski. Thank you.

Any questions of the witness?

Mr. Burleson?

Mr. Burleson. Thank you, Mr. Chairman. Doctor, I recall you were chairman of the board of trustees of our Texas college of osteopathic medicine?

Dr. Luibel. Yes, sir, I was.

Mr. Burleson. I especially welcome you before the meeting.

From what you say, I gathered you feel the entire medicare fees to specialists somewhat influence postgraduate training decisions.

Is that your opinion?

Dr. Luibel. Well, I think it works this way, Mr. Burleson. A physician's service or service to a patient for which a fee is collected or whoever pays the fee, patient, government, or other third party, has to be rendered by a licensed physician.

Actually, whoever the physician is, he is taking the same responsibility to the patient in terms of care and legal responsibility and to the State and to the medical community which permits him to practice this way.

So, it really does not make good sense if I render the care and somebody else renders the care and we are paid different amounts for the same care when we take the same responsibility and students look at this sort of thing.

They say: If I do a tonsillectomy as a general practitioner after qualifying myself to do this procedure and you are going to pay me *x* number of dollars and you pay the fellow down the street with a specialty rating *x* number of dollars, I am at a disadvantage.

I think this is the factor we are talking about.

Mr. Burleson. I take it you feel that uniform fees for any given medical service would perhaps curtail some ~~of~~ the specialty maldistribution?

Dr. Luibel. Well, hopefully, it would certainly encourage the primary-care physician to remain that, as such, than to go into that field of medicine.

Mr. Burleson. Thank you and thank you, Mr. Chairman.

Mr. Rostenkowski. Thank you.

Dr. Luibel. Thank you, Mr. Chairman.

Mr. Rostenkowski. Next are Mr. Godkins and Mr. Fisher.

Have you made statements available to the committee, Mr. Godkins and Mr. Fisher?

Mr. Godkins. Yes; I have.

Mr. Rostenkowski. Welcome to the committee, gentlemen, and if you will identify yourselves and proceed with your testimony, the committee is ready to listen.

STATEMENTS OF THOMAS R. GODKINS, IMMEDIATE PAST PRESIDENT, AND DONALD W. FISHER, EXECUTIVE DIRECTOR, AMERICAN ACADEMY OF PHYSICIANS' ASSISTANTS

Mr. Godkins. I am Thomas R. Godkins, immediate past president of the American Academy of Physicians' Assistants and currently chairman of its goals and priorities committee and currently I am employed by the University of Oklahoma in the department of family practice and community health as a director of its physician's assistants program. I am accompanied by Dr. Donald Fisher, executive director, of the American Academy of Physicians' Assistants.

I will keep my remarks brief and would like to request that my more extensive written testimony be accepted for the record.

Mr. Rostenkowski. Without objection, the entire statement will be included in the record.

Mr. Godkins. Approximately 1 year ago, I was honored to make a presentation before this committee on medicare reimbursement vis-a-vis physician extender patient care services. At that time I pointed to the ironic contradiction in Federal policy providing millions upon millions of dollars through HEW to educational institutions, to train physician extenders, and yet disallow medicare reimbursement of physicians and/or practices for the services rendered by these new practitioners.

Unfortunately, today, the reimbursement problem remains unresolved, in my opinion putting at risk the continued viability of the physician extender concept. The committee and the U.S. Congress have addressed problems confronting health care delivery and I think responded with the appropriate legislation. We still see a maldistribution of physician manpower and need for more family physicians and still see limited access to medical care for many Americans, and still see new providers, physician assistants not being utilized to full potential, all of this compounded by a general economic inflation with an inflationary rise in medical costs. More must be done. Accessible medical care of good quality must become a reality for all Americans, especially those in rural areas. Let us all not forget the American public is a taxpayer whose money goes for support of medical education and whose money contributes to the social security programs.

I would like to recommend to the committee the following: one, an attempt be made to shift physician manpower in geographic distribution and by discipline, with economic incentives through the medicare program.

Physicians have often opted to specialize and practice in urban affluent communities where customary increases in medicare payment are found. At least it would seem reasonable to develop a consistent reimbursement policy where a practitioner is reimbursed for his services at the same rate. At the very most, one could consider authorizing discriminating increased rates of reimbursement to practices and practitioners committed to primary care in geographic areas of need.

Two, under congressional authority provided by the Social Security Administration Amendments 1972, H.R. 1, the Social Security Administration has been conducting a nationwide study attempting to evaluate alternative methods and amounts of reimbursement for physician extender services. The study seeks commendable outcomes but has faced many, many problems. This study, which was authorized in 1972, is today costing Federal taxpayers millions of dollars and is not scheduled for completion until December 1979. It would seem appropriate for the Congress to reexamine this study immediately and call for its acceleration in time, not scope, which from my perspective, would not compromise the study and yet allow for its appropriate completion.

Through the study practice, identification data will be available this year. Through the study practice, productivity will be available this year and next and the Social Security Administration is about to award a major contract within the next few days to carry forth the study of reimbursement.

Let me go on. Another recommendation is this. Three; physician assistants patient care services are often not reimbursable under title 18 of the Social Security Act. I support legislation submitted by Representatives Symington and Duncan, H.R. 14833, and in the Senate, S. 3644, submitted by Senator Pearson from Kansas and Senator Huddleston from Kentucky. In my mind these bills would improve accessibility and physician extenders could be utilized to their full potential and physicians would be given incentive to accept the assignment of claims for medicare beneficiaries realizing they would get reimbursement for services offered by the physician extenders.

These bills would also have impact upon costs. I feel, reducing the cost of health care. Patients would not be forced to pay out of their own pockets dollars for services not currently authorized.

Legislation must be passed to authorize payment under the supplementary medical insurance program for patient care services furnished by physician assistants. Reimbursement to practices and/or physicians should be at a consistent rate no matter who the provider. Reimbursement should be allowed only if the physician assistant is under the responsible supervision of a licensed physician in accordance with the prevailing medical practice laws of the State.

I would like to conclude by quoting the Governor of North Carolina, and I may mispronounce his name and I apologize. Governor Holshouser who appeared before the subcommittee and I thought had a very commendable statement. He, as I, is concerned about constraining Federal health care expenditures and that is an admirable objective which I think the committee must object but Governor Holshouser went onto state, "The attempt to fight this battle by denying primary care reimbursement to our rural residents is not only to lose the battle, but also to fail to identify the enemy."

I sincerely hope the committee has found my comments worthwhile. I would be glad to address questions after, with your permission, Dr. Fisher makes a few brief remarks.

Mr. ROSTENKOWSKI. Yes.

Mr. FISHER. Mr. Chairman, I want to thank you for the opportunity to provide this testimony on behalf of the American Academy of Physicians' Assistants on the revisions of the medicare physician reimbursement system. I'm Dr. Donald W. Fisher and I am the executive director of the American Academy of Physicians' Assistants and the Association of Physician Assistant Programs. Prior to my current position I was a member of the faulty of the University of Mississippi School of Medicine and Co-Director and executive officer of the University of Mississippi Physicians' Assistant Program.

Mr. Chairman, my purpose in being here today is to recommend revisions in the medicare physician reimbursement system such that phyicians would be reimbursed under title XVIII of medicare (part B) for those services rendered by physicians' assistants.

Ten years ago, one of the major premises of the physicians' assistant concept was the hope that these mid-level practitioners would distribute themselves in such a way as to help redress the geographic maldistribution of health care. Indeed, the evidence is that they have done so. A survey by the American Academy of Physicians' Assistants and the Association of Physician Assistant Programs, of the 2,500 graduates of federally funded programs through 1974, revealed that 42 percent of graduates are employed in nonmetropolitan counties of populations from 10,000 to 50,000. Today, this already available solution to the medical maldistribution problem in this country remains little used because those patient services provided by physician assistants, under supervision but without the immediate presence of the physician employer, are not included in the range of medicare's reimbursable services.

Since 1972, both the Congress and the administration have called for the development of alternative plans of health care delivery, which can provide needed additional access, and be of high quality, at an affordable cost. The physician assistant concept has done this. Mr. Chairman, in testimony delivered before the House Ways and Means Subcommittee on Health in Knoxville, Tenn. on July 23–24, Harry Teter, Jr., executive director of the Appalachian Regional Commission stated that they "believe physician extenders to have proven themselves to be effective." He further stated

> . . . the satisfaction of the rural and urban users, plus the quality studies by Johns Hopkins, Harvard, Yale, Columbia, Vanderbilt, the University of North Carolina, the University of Tennessee, and other medical schools have shown this effectiveness. Together, all of these studies show that the use of physician extenders results in reduced hospitalizations, reduced overall health care costs, and by inference, a potential means to reduce costs to the third party payor.

I believe that the lack of medicare reimbursement is a roadblock to the ultimate utilization of physician assistants. The solution to this roadblock is to include physician assistant services in the definition of "medical and other health services" in part B of title XVII. To insure quality and continuity of medical care, these services should be made part of "physician services" (section 18761(s)).

Further, payment for physician assistant services should be made to the practice in which the physician assistant is employed. In addition, these practices should also be encouraged to accept medicare assignment, thereby decreasing the paperwork burden on the medicare beneficiary.

The American Academy of Physicians' Assistants believes in reasonable and appropriate reimbursement for physician assistant services. We have discussed with Jay Constantine, of the staff of the Senate Finance Committee, legislation which would, as a minimum, provide reimbursement for physician assistant services in medically underserved areas at an even lesser percentage of that which the physician usually and customarily receives. We have also discussed with Mr. Constantine a nontraditional format in reimbursement: a medicare payment formula. This formula stimulates an increased use of physician assistants without lending itself to expolitation of the part B medicare program. Nathan Hershey, professor of health law at the University of Pittsburgh, after reviewing our formula, commented that when simulations were used in applying the formula, the medicare program saves money. He further stated that if, with this formula, a physician assistant enabled the physician to expand his practice, the unit cost of service to the Government would decrease.

We have also discussed reimbursing physicians for physician assistant services at the usual and customary rate: the same fee for the same service, irrespective of the location of the practice. In this approach we believe the cost to the medicare program would not increase expenditure but, in fact, would result in net savings. This conclusion is based on the measured experience in rural areas where physician assistants services are available.

Now is the appropriate time for Congress to take action on this issue. Even if national health insurance is imminent, it will be of little use to persons who do not have access to health care services.

Thank you.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN ACADEMY OF PHYSICIAN'S ASSISTANTS[1]

Mr. Chairman and members of the committee, I am Thomas R. Godkins, immediate past president and chairman of the goals and priorities committee of the American Academy of Physicians' Assistants, and I am here today to offer testimony on the Medicare reimbursement system. I am a graduate physician's assistant who has practiced in a remote primary care clinic and currently am employed by the University of Oklahoma as an assistant professor in the department of family practice and community medicine and dentistry while serving as associate director of the physician's associate program. I am pleased to have this opportunity to testify and am accompanied today by Dr. Donald W. Fisher who is executive director of the American Academy of Physicians' Assistants.

MEDICAL CARE AND THE PHYSICIAN'S ASSISTANT IN THE UNITED STATES

The United States Congress has identified and attempted to address in a pragmatic and economical fashion the inequities and injustices in the American health care system. Admittedly, American medicine has improved the quantity and quality of medical care since the publication of the classic report on medical education by Abraham Flexner in 1910. However, challenges continue to face the American health care system inclusive of, but not limited to changes in population size and composition, general economic inflation with an inflationary rise in medical costs, limited "access" to medical care, and a high mortality and morbidity rate for an industrial nation. Evidence to support these claims is visible: the state of our economy, an extremely mobile population base, a significant physician manpower pool which unfortunately is maldistributed, and through comparisons of age-specific death rates and life expectancies. Accessible medical care of an acceptable quality is not a reality for many Americans. "Access" is a problem which can be directly related to cost and a maldistribution of consumers and the physicians capable of providing primary care. Victor R. Fuchs in his book entitled, *Who Shall Live?*, believes "the most important reasons for current complaints about access . . . is the growth of specialty practice within medicine . . . and . . . finding a physician who will take continuing responsibility for the patient. . . ."[2]

Many rural Americans find themselves without medical care and this country's ability to provide sound preventive health programs is limited by cost and health manpower constraints. Admittedly, consumers intensify these problems by risking long-term "health" for short-term hazards, such as smoking, getting little exercise, eating poor diets, and not complying with medical therapy as directed by health practitioners. Sound preventive health programs and an improvement in patient compliance (through patient education) seem to be sound long-term investments. Should we, in an attempt to make medical care more available to rural Americans, train increasing numbers of physicians and physician's assistants? With real concerns relative to cost, I concur with Fuchs who believes

---

[1] Presented by Thomas R. Godkins, immediate past president and chairman, goals and priorities committee, American Academy of Physicians' Assistants, to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, September 15, 1976.

[2] Fuchs, Victor R., *Who Shall Live?*, Basic Books, Inc., (New York, New York, 1975), pp. 68–69.

". . . demand for access can not be met for the total population by personnel now known as physicians (such personnel are too expensive) . . . and . . . an efficient effective solution to the access problem requires the deployment of properly trained, properly supervised . . . physician's assistants."[3] It would seem reasonable to train more primary care physicians who will practice in geographic areas of need and to train more physician's assistants whose cost of education is substantially less than that of the physician.

CONGRESSIONAL SUPPORT OF THE PHYSICIAN'S ASSISTANT CONCEPT

The Congress of the United States has been supportive of the physician's assistant concept and, subsequently, testimony has been offered on reimbursement problems confronting this profession. Since the passage of the Comprehensive Health Manpower Training Act of 1971, the Bureau of Health Manpower Education (Health Resources Administration, D.H.E.W.) has provided significant support to institutions with physician's assistant training programs. Continued support for training programs is planned through the Comprehensive Health Manpower Education Bills submitted this year by Representative Rogers and Senator Kennedy.

Testimony has been provided the Subcommittee on Health of the Committee on Ways and Means relative to Medicare reimbursement of physicians and physician extender services. A "Position Statement on Medicare Reimbursement for Physician Extender Services" was provided the Subcommittee on Health in September, 1975 and testimony on the "Social Security Medicare Reimbursement Study for Physician Extenders" was offered to the Oversight Committee in May 1976. This testimony highlighted the inability of the supplemental medical insurance program to adequately authorize Medicare Part B reimbursement for physician's assistant services [Section 1861(s)(2)(A)] and reviewed the Social Security Administration study of physician extender reimbursement. Unfortunately, as the testimony offered earlier reflects, the reimbursement situation for physician's assistants remains unresolved to the detriment of the profession, the American physician, and most importantly, the American public.

RECOMMENDATIONS RELATIVE TO THE MEDICARE REIMBURSEMENT PROGRAM

I would like to comment on the inequities in the Medicare reimbursement program for physicians, endorse previous testimony provided this Subcommittee, respond to legislation introduced to amend Title XVIII of the Social Security Act, and briefly discuss the ongoing experimental study of physician extender reimbursement by the Social Security Administration. The following are of specific concern:

(1) Physician's assistants are being trained in increased numbers and yet, under Title XVIII of the Social Security Act, reimbursement to the physician for their services under the supplemental medical insurance program is not authorized. Physicians currently employing physician's assistants are not being given any incentive to accept the assignment of claims for Medicare beneficiaries since they realize refusal of Medicare reimbursement for the services rendered by their physician's assistant is a distinct possibility. This bill, in turn, promote rather than improve the problems consumers face in accessibility to appropriate medical care.

(2) Economic incentives rather than economic barriers must be developed if shifts in *physician* manpower distribution are to be realized. Many physicians have opted to practice in "urban-affluent" communities creating a maldistribution of their manpower pool. Physicians prefer to practice in highly urbanized areas where the customary and reasonable rates of reimbursement allowed are often higher than those allowed in small, rural communities. Admittedly, physicians also opt to practice in urban areas to utilize up-to-date facilities and enjoy the educational, recreational, and cultural facilities available to them and their families. However, the economic incentive must be viewed as a critical problem. Perhaps, discriminating increased rates of reimbursement should be allowed rural physicians who practice in health scarcity areas as defined by the Secretary.

(3) Economic incentives have been provided the physician to specialize (in surgery for example) rather than opt for primary medical care as a family

---

[3] Fuchs, Ibid.

physician (general practitioner, pediatrician). A surgeon in a rural town in Oklahoma could be reimbursed for the same routine reoccurring "primary care task" higher than for the same service provided by a family physician. At the very least, it would seem reasonable to develop a consistent reimbursement policy whereby practitioners are reimbursed for a given service (of the same quality) at the same rate. Once again, one could consider developing "discriminating" increased rates of reimbursement to primary care practitioners in rural practice in health scarcity areas.

(4) Under Congressional authority provided by the Social Security Amendments of 1972 (HR 1, PL 92–603, Sec. 222) the Social Security Administration has been conducting a nation-wide study attempting to evaluate alternative methods and amounts of reimbursement for physician extender services. The study seeks commendable outcomes, but has faced many problems: numerous project objectives with resultant complexity in the study's design; authorized in 1972 and yet not operational until 1973; delayed implementation of fieldwork for many reasons inclusive of OMB clearance; and the resultant delay in project completion—practice identification data (1976), practice productivity data (1976/77) and practice reimbursement data (1977/78). This study, which was authorized in 1972 and is costing the federal taxpayers millions of dollars, is not scheduled for completion until December, 1979. It would seem appropriate for the Congress to review this study and call for its acceleration in time (not scope) which from my perspective would not compromise the study and yet allow for its appropriate completion.

(5) Legislation has been submitted to amend the Social Security Act, specifically the supplemental medical insurance program, to provide reimbursement under Medicare Part B to physicians and/or practices for patient care services rendered by physician's assistants. In 1975 Representative Broyhill (North Carolina) submitted HR 7218 and Senator Bellmon (Oklahoma) submitted S 1897. In 1976 Representative Symington submitted HR 14833 cosponsored by Representatives Landrum (Georgia) and Duncan (Tennessee) and Senators Pearson (Kansas) and Huddleston (Kentucky) have submitted S 3644. In the House, the bills were referred to the Committee on Ways and Means and in the Senate each bill was referred to the Senate Finance Committee. The proposed legislation reflects a growing Congressional interest in providing reimbursement to physicians and/or practices for patient care services rendered by physician's assistants. We support the enactment of legislation which will amend Title XVIII of the Social Security Act to authorize payment under the supplementary medical insurance program for services furnished by physician's assistants under the responsible supervision of a licensed physician.

(6) I endorse the previous testimony provided this Subcommittee by other individuals knowledgeable in the area of health manpower and Medicare reimbursement. The Subcommittee has receive supportive testimony for the physican's assistant concept from Dr. Vernon E. Wilson, vice chancellor for medical affairs at Vanderbilt University and from the Governor of the State of North Carolina, the Honorable James E. Holshouser. In addition, the Subcommittee is aware of the valued opinions of individuals like Dr. Richard Cannon, chairman of the National Advisory Committee on the Accreditation of Allied Health Programs for the American Medical Association, who has a personal commitment to the concept of physician's assistants in rural health care clinics.

SUMMATION

I urge the Subcommittee on Health of the Committee on Ways and Means to consider my remarks and recommendations as they relate to the Medicare reimbursement system. Through the Medicare reimbursement system economic incentives could be provided the physicians to practice in a primary care discipline and/or in a geographic area deficient in health manpower. At the very least, it would seem reasonable ao develop a consistent reimbursement policy whereby practitioners are reimbursed for a given service (for which they were trained and certified or licensed to perform) at the same rate. Practices committed to primary care deserve to be reimbursed under the supplemental medical insurance program for patient care services rendered by physician's assistants under the responsible supervision of a licensed physician(s). The Social Security Administration study of physician extender reimbursement should be accelerated and completed by December, 1977 to allow for the appropriate development of reimbursement legislation.

Physician's assistants are enabling our health care system to make quality medical care more accessible to Americans who do indeed have the right to health care at a reasonable cost. Representatives Rostenkowski and Duncan have seen firsthand the utilization of physician's assistants in the Clear Fork Clinic in Clairfield, Tennessee. Physician's assistants are practicing in geographic areas deficient in health manpower and offer great potential for decreasing the cost of medical care while increasing its accessibility to the consumer. Constraining federal health care expenditures is an admirable objective, but as stated by Governor James E. Holshouser, Jr. (North Carolina), "to attempt to fight this battle by denying primary care reimbursement to our rural residents is not only to lose the battle, but also to fail to identify the enemy."[4] It is indeed unfortunate American medicine faces this reimbursement dilemma for it is the physician's assistant profession, and most importantly the American consumer who is currently being penalized.

Thank you for inviting me to testify.

Mr. Rostenkowski. Thank you very much.

Mr. Duncan?

Mr. Duncan. Thank you, Mr. Chairman. It has been indicated that perhaps the cost would be prohibitive to support physician extenders in both the rural and urban centers. Would you have views of perhaps extending it at first to the rural areas or first to the urban centers or what?

Mr. Godkins. That has been discussed and the information we have from the academy shows we have reasonably good diffusion of physician extenders, family practitioners, and PA's to rural and whether you would maintain that diffusion by screening of reimbursement is I suppose a reasonable approach.

I, however, personally feel that the problem is one of access and that the reimbursement should be at the same rate no matter who the provider is. I think that has good potential and has merit.

Mr. Duncan. I feel you do and I just wondered what your views would be.

Now, you mentioned the study that was provided by Public Law 92-603 and the delay. I am requesting a special order for today or tomorrow to enter summaries of mine on this delay in the study and I notice from the report of the Comptroller General, April 8, 1975, that they indicated that the study should be expedited. There is apparently 4 years now and they have done very little and it is hard to get relevant answers. Mr. Chairman, I would like, if I may, that my remarks in my special order be entered as part of the record concerning the required study.

Mr. Rostenkowski. There being no objection, it is so ordered.

Thank you, gentlemen.

Mr. Godkins. Thank you very much, Mr. Chairman.

[The material referred to by Mr. Duncan follows:]

[From the Congressional Record, Sept. 15, 1976]

THE PROBLEM OF REIMBURSING "PHYSICIAN EXTENDERS" UNDER MEDICARE

The Speaker pro tempore. Under a previous order of the House, the gentleman from Tennessee (Mr. Duncan) is recognized for 30 minutes.

Mr. Duncan of Tennessee. Mr. Speaker, the Congress, in the Social Security Act Amendments of 1972 (P.L. 92-603, section 222(G)) directed the Social Security Administration to study how and when medicare reimbursement for services provided by assistants to physicians is appropriate.

---

[4] Holshouser, Jr., James E., Governor of North Carolina, "Statement to the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives," presented on July 23, 1976.

I am concerned about a special group of these, "physical extenders," those professionals who are trained to provide medical diagnosis and treatment under the supervision of a physician. They work primarily in the field of primary health care and most locate in medically underserved areas of inner cities and rural counties.

I am also concerned about this study because in the 4 years since it was authorized, it has produced not even preliminary results and the need for answers is imminent.

Today, hundreds of "exender" clinics are temporarily supported by grants from the Appalachian Regional Commission, the Public Health Service, and State governments, such as Tennessee and North Carolina, Arizona, and New Mexico to provide primary health care in otherwise medically underserved areas. Oftentimes in these clinics physicians are not physically present. Because of this these clinics are not now eligible for medicare reimbursement. The fact is—they cannot financially survive without reimbursement for services to their medicare patients. Medicare patients account for 10 to 15 percent of their registrants, in many areas, and in some for as much as 30 percent of their visits.

Again today, through the Bureau of Health Manpower, National Institutes of Health, we are spending in excess of $15 million per year to train more extenders. Already, the training programs are finding that jobs for the new extenders are limited to grant programs, because their services are not reimbursable.

The medicare—social security study involves temporary "experimental" reimbursement for services provided by physician extenders. We are told that extenders are permitted to self-select into the study—thus offering the clinics an interim solution to the reimbursement problem.

At this point in the Record, I would like to include a copy of a letter from an Appalachian clinic that employs an extender and sought to be included in the study. They were turned down because the extender graduated in the wrong class. Apparently, this arbitrary turndown is not unique. Very few of the 107 extender clinics supported by the Appalachian Commission are included in the social security study. None of the North Carolina clinics are included.

The letter follows:

St. Charles Community Health Clinic,
St. Charles, Va., August 24, 1976.

Senator Harry Byrd,
U.S. Senate, Washington, D.C.

Dear Senator Byrd: We understand that legislation has been introduced into the House and Senate that will require Medicare to reimburse nurse practitioners, physician assistants, and other "physician extenders" for services rendered to Medicare beneficiaries. The Senate Bill is S. 3644. The passage of this legislation is crucial to the future success of small, community-owned, primary care clinics in rural Virginia such as the St. Charles Community Health Clinic. We provide a valuable service to a population comprised mainly of retired working men and their families who live on fixed incomes. We try to keep them healthy and out of the hospital.

The St. Charles Health Council employs a Family Nurse Practitioner (FNP); Polly McClanahan, R.N.; who has been seeing patients at the clinic since January. Ms. McClanahan is certified in Virginia as a Family Nurse Practitioner by the Joint Boards of Medicine and Nursing. As a FNP she practices medicine according to written protocols and under the supervision of a private physician in Jonesville. She screens, diagnoses, and treats patients according to her protocols, consults via the telephone with the physician when she has questions, and makes appropriate referrals to other physicians and services. She is accepted as the "little woman doctor" in the community and is able to see fifteen to twenty patients a day by herself.

The St. Charles Community Health Clinic maintains a single fee schedule and charges appropriate fees for the services that the FNP provides. The supervising physician and the FNP receive a set salary from the Health Council.

The Virginia Medicaid program and the UMWA Health and Retirement Funds reimburse the physician for the services their beneficiaries receive; and the physician reimburses the clinic. Although the FNP sees Medicare patients, Medicare will not reimburse the physician for services provided by the FNP unless the physician is physically present when the FNP is providing the services. We must schedule all our Medicare patients for the few hours each week that the physician spends at the clinic.

On one hand, we will not deny Medicare patients services at the community clinic they helped to build. These people are old, disabled, chronically ill, and without transportation. They do not have the financial resources to pay for the care they receive at the clinic without the help of Medicare. However, if the clinic does not receive reimbursement for the growing number of older patients we see, then we will never become self-sufficient and consequently unable to offer medical care to anyone.

A study has been authorized in 1972 by the Social Security Administration to determine if and how physician extenders should be reimbursed. We have been patient and tried to participate in the study, but our FNP is ineligible because she completed her training program three months after the study's arbitrary cut-off date. We have now been informed that due to the complexity of the research design and the cost of conducting the study that valid results will not be available until 1980. We cannot wait that long!

This pending legislation is crucial to the future solvency and viability of the clinic. As you know, the people of St. Charles have financed, built, equipped, and staffed the clinic. The clinic did not receive any Federal help until July 1976. The grant that we have received is to offset deficit expenses for the first few years until we become self-sufficient. However, we will never become self-sufficient unless we receive payment for the services we provide. The Federal government encourages the development of primary care clinics managed by local communities, but at the same time a Federally funded health program discourages the delivery of care to the old and poor.

We ask for your help in supporting this legislation. But more importantly, we ask that you join with your colleagues in the Senate in co-sponsorship of S. 3644. The St. Charles Community Health Clinic is not an isolated clinic in Southwest Virginia. Residents in Ewing, Rose Hill, Dungannon, Ft. Blackmore, Hurley, Dickenson County, Washington County have organized and begun to develop similar programs.

We would appreciate it if you would consider our request and inform us of your decision. We are not asking for more money. We want to deliver quality health care to the people in Southwest Virginia and we want to pay our own way!

Sincerely,

NANCY RAYBIN,
Administrator.
LINDA ALSUP,
President.

With so many exclusions, the study cannot possibly be an interim solution.

According to public information from SSA final study results will not be available until 1979 or 1980. Most of the clinic grants will terminate before then.

Apparently some others within the Social Security Administration share my concern about this delay. I have just recently learned of plans to contract this fall for an evaluation of data for purposes of producing a preliminary report by December 1977. Even this is 6 years from the date of the law asking for this information, and 2 years from the date that GAO recommended that Congress press for early results.

This whole area requires a thorough investigation at the highest levels within the Department to answer the question raised by this situation. A full report should be made to the Ways and Means Committee in the next 10 days, giving the full and complete detail about this study, including answers to the following questions:

1. What is the current status of the study authorized by P.L. 92–603, the 1972 Amendments to the Social Security Act, concerning experimental Medicare reimbursement for physician extenders?
2. When will the study be completed? When was it started? When will you have any, even preliminary, results? How much has been spent on the study from 1972 through June 30, 1976? What is the budget for FY 1977, FY 1978 and FY 1979 for this study?
3. Why, after four years, are the available results confined to information on location of physician extenders? What was the cost of obtaining these data?
4. Is the design for the analysis of data from the reimbursement phase of this study complete? If so, please submit copy. If not, why not?

Is the contractor for this reimbursement analysis phase selected?

Does the study have any more phases? If so, what are they?

5. Please submit a list of the names and locations of extenders participating in the study.

How many and what percentage of them are in rural areas?

How many extenders did you contact in developing the list of participants?

On what grounds were extenders eliminated from participating in the study?

Why did so many extenders voluntarily choose not to participate?

6. What requirements are imposed on participating extenders in order that they may receive reimbursement under the constraints of this study?

What information must be submitted to your office?

How long does it take an extender to complete these forms?

7. One of the purposes of the study mandated by P.L. 92–603 is "to determine under what circumstances payment for services would be most appropriate." How will this question be addressed?

Does the study design include information on whether use of extenders reduces overall costs to the Medicare system, such as reduced hospitalization?

Are you or the research managers familiar with the published studies of Dr. Runyan of the University of Tennessee Medical School concerning reduced health care costs through reduced hospitalizations by using extenders?

I believe a Mr. Mendenhall, Ph. D., of University of Southern California, is the chief contractor on this study. Is he aware of the cost savings effected by use of extenders at UCLA Medical Center as published in the Fogarty International Library Series?

Why isn't the study oriented towards overall savings to the health care system, by use of practitioners, not just the method of payment for practitioners? Isn't that the important question?

8. Are you aware that Medicare beneficiaries constitute as much as 12 percent of the registrant population and 25 percent of the total visits to rural clinics?

This study which has seriously run amok is being cited as the reason why we should not amend the Medicare law to reimburse "extenders."

On the contrary, this study has produced nothing in 4 years, even when its finished in 7, 8, or 9 years, it will not have answered the key questions concerning reimbursement of extenders. This study is no reason to delay legislation to allow this reimbursement. I strongly recommend passage of H.R. 14630 as soon as possible.

I include the following:

ATTACHMENT

"(G) to determine under what circumstances payment for services would be appropriate and the most appropriate equitable, and noninflationary methods and amounts of reimbursements under health care programs established by the Social Security Act for services, which are performed independently by an assistant to a physician, including a nurse practitioner (whether or not performed in the office of or at a place at which such physician is physically present), and—

"(i) which such assistant is legally authorized to perform by the State or political subdivision wherein such services are performed, and

"(ii) for which such physician assumes full legal and ethical responsibility as to the necessity, propriety, and quality thereof;"

REPORT TO THE CONGRESS: PROGRESS AND PROBLEMS IN TRAINING AND USE OF ASSISTANTS TO PRIMARY CARE PHYSICIANS—DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

(By the Comptroller General of the United States)

* * * * * * *

REIMBURSEMENT FOR SERVICES

HRA and IHS provide financial assistance for training physician extenders, but SSA is not providing reimbursement for extender services under part B of the Medicare Program, which provides for payment of physicians' services on a reasonable charge, fee-for-service basis. According to SSA, part B of Medicare does not allow payment for services traditionally performed by physicians unless they are the kinds commonly furnished as a necessary adjunct to the physician's personal in-office services. SSA may reimburse institutions, however, for physician extender services under part A of Medicare as it does for the services of any salaried employee of a hospital or extended-care facility.[1]

In 1965, when the Medicare legislation was enacted, there were few, if any, physician extenders working, and no allowance was made for their reimbursement.

The issue of reimbursement came to a head on May 10, 1971, when an SSA official in Boston wrote to a New England Medicare coordinator that

"The question of whether payment may be made for the services of physician assistants who are physician employees depends—on whether they meet the requirements of Section 1861(S)(2)(A) of the [Social Security] Law which provides coverage of services 'furnished as incident to a physician's professional services of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physician's bills'."

The letter concluded that "Some of the services physician assistants would perform would not presently meet the 'commonly furnished in physicians' offices' requirement."

SSA regulations specify that services to be covered under section 1861(S)(2)(A) of the Social Security Act must be of kinds that are "commonly furnished" as a necessary adjunct to the physicians' personal in-office services. Thus, according to the Medicare law, the performance by a physician extender of services traditionally reserved to physicians cannot be covered under part B of Medicare even though all other requirements have been met.

Responding to this problem, the Congress in the Social Security Amendments of 1972 provided that a study be made to determine (1) under what circumstances payments to physician extenders would be appropriate, (2) what payment methods would be the most appropriate, equitable, and noninflationary, and (3) how large the reimbursements should be that are paid under health programs authorized by the Social Security Act. A contract covering the first phase of this study—designing a data collection, evaluation, and analysis initiative—was let in February 1974. The study itself began in December 1974.

According to an official of SSA's Bureau of Health Insurance, letters have been sent to third-party carriers asking them to review bills submitted by doctors employing physician extenders. This official advised us that insufficient audit capability exists, however, to review every bill submitted by a physician employing an extender. Consequently, SSA is probably unknowingly reimbursing physicians for services rendered by extenders under part B of Medicare.

We contacted a number of health insurance carriers to determine their practices regarding reimbursement for physician extender services. The private carriers were reimbursing for physician extender services if:

The extender was employed by and under the supervision of a physician,

Extenders were legally recognized in the State, and

The fee was in accordance with "reasonable and customary" charges.

MALPRACTICE CLAIMS AND INSURANCE

With one exception, we found no evidence of any malpractice claims filed against physician extender graduates or their employing physicians for work performed by an extender. The only instance of any such claim we observed involved a physician associate student at Duke University who was assisting a physician in the university's hospital. The malpractice claim resulted from an act that took place in September 1971, and at the time of our visit, the case had not yet come to trial.

According to physician extenders, employing physicians, and insurance companies, malpractice insurance is available to extenders. An exception was in California, where, because of legal uncertainties, the availability of malpractice insurance at the time of our review was in doubt.

Of the 306 physician extenders responding to our question on this point, 297 had some sort of malpractice coverage, either through individual coverage, under a rider of the employing physician's policy, or under the umbrella coverage of the employing institution. In some instances, nurse practitioners were covered by the same policy that protected them when they practiced solely as registered nurses.

---

[1] In commenting on our draft report, HEW said there may be exceptions when reimbursement would not be provided under part A of Medicare. (See app. I.)

CONCLUSIONS

Physician extenders have generally improved the accessibility and quantity of medical care provided in their employers' practices. The expense of their salaries and additional malpractice insurance premiums has apparently not inhibited their employment.

Fees charged by practices employing physician extenders are based on the services provided, not on the person providing the service. Thus, the same fee is charged whether the services are provided by a physician or an extender.

The issue of reimbursing for physician extender services needs to be resolved. HEW should conduct the study required by the Social Security Amendments of 1972 in an expeditious manner and use the results as they become available to resolve this matter.

RECOMMENDATION TO THE SECRETARY, HEW

We recommend that the Secretary of HEW insure that the study required by the Social Security Amendments of 1972 is conducted expeditiously and use the results as they become available to resolve the problems concerning the reimbursement for services provided by physician extenders under the Social Security Act.

Mr. Rostenkowski. Next is Mr. Morderosian.

Welcome to the committee. Will you identify yourself and proceed with your testimony?

STATEMENT OF LAWRENCE D. MORDEROSIAN, PORTLAND, OREG.

Mr. Morderosian. Mr. Chairman and members of the committee, I am not representing anybody except my father and his thinking. He is 85. He just got out of the hospital after treatment for a broken hip twice.

He could not make these hearings. He wanted me to come in his place. I got involved in it because of the cost of medical attention he had at the hospital.

I would like to read my statement, and if possible, have it made a part of the record.

Mr. Rostenkowski. Yes.

Mr. Morderosian. There are a lot of attachments and I have a lot of background in documenting.

My name is Lawrence D. Morderosian, and I reside at 2145 NW. 135th Avenue, Portland, Oreg., 97229. I am making this presentation on behalf of my father, Lyon Morderosian, age 85 years.

My father was unable to attend this hearing due to recent hospitalization for a broken hip. I have the required legal documentation, whereby I have full power of attorney to represent and speak for my father.

Let me briefly outline my personal background in order to lend some credence to my testimony.

I am a disability retired military officer with 21 years of military service. I have 12 years experience as a licensed management and investigative consultant.

The majority of my work involved allegations of corporate fraud, international business acquisitions, feasibility studies, counter-industrial espionage, et cetera. My cases were both domestic and international in scope.

I am now a contract specialist employed by the Federal Government. On December 16, 1976, I will complete the requirements for a masters degree in business administration from the University of Portland.

I have one year of law school, which was ended when I was recalled to active duty for Korea in 1951.

My father injured his hip on April 4, 1976. I took him to Good Samaritan Hospital in Portland, Oreg., for medical determination.

When the injury was confirmed, I had him admitted to St. Vincent's Hospital, since it was closer to our home. The cost for my father's 3-hour stay at Good Samaritan Hospital, in a wheelchair, was $114.20, mainly for X-rays, $73. Sitting in the wheelchair cost $25, while the physician's cost was $12. The remainder was under "miscellaneous treatment".

Within a week after the hip surgery, the doctors determined that complications had caused bladder infection, and a prostate operation was necessary.

Finally, after 29 days, my father was discharged from the hospital. The cost for the hospital room, board, and incidental services was $5,455.15. Ten days later while my father was taking a bath, he broke his hip again. This hospitalization required 17 days, and a cost of $4,565.65.

My first taste of the defects in the medicare health insurance program began several weeks after my father returned home.

The medicare carrier for Portland is the Aetna Life and Casualty Insurance Co. of Hartford, Conn. The Aetna checks for physicians' services began to arrive in early June 1976.

I was shocked by the disparities in physicians' billing charges, and the amounts determined by Aetna, to be "fair and reasonable" in payment for services rendered.

Please refer to attachment A for most medical charges received and the cost determination made by Aetna. You will note that the denial of some charges goes as high as 42 percent.

The question of the delegation of total fiscal and judicial authority, by a Federal agency, to private industry, via an agreement, will be discussed more fully in a separate statement.

When I began research into the reasons for denial of physicians full billings by Aetna, by telephone, I ran into a blank wall.

The information I received was totally negative and noninformative. I decided to contact the Social Security Administration, medicare program officials in Seattle, Wash.

I drove there and visited several officials who were extremely courteous. However, I learned that the medicare agreement is administered from the Social Security Administration office in Boston, Mass.

These officials advised me that the Aetna Co. had total control over the part B of the medicare insurance program in Portland.

That the determination on "fair and reasonable" cost for physician services was made by Aetna, who fed information from local doctors into its own computer system in Hartford, Conn.

Finally, that the costs found in the 75 percent quantrile, were deemed to be "fair and reasonable" by Aetna. The SSA personnel also advised me that if a patient believes that the carrier was wrong in denying full 80 percent payment on a medical cost, he or she has a right to request review of the denial by Aetna.

If this denial is upheld, then the patient can request a formal hearing on the matter, that the hearing officer is an attorney assigned to the Los Angeles Aetna Insurance Co. office, who files here for the hearing and, finally, that the carrier has final authority on the claim, that the patient cannot appeal to any other authority.

When I returned to Portland, I attempted to obtain information, by correspondence, from Aetna. This was to no avail. I requested that more detailed information was to be provided when a charge was denied as being excessive.

The only reference to the reason for denial is "see item on back". This says nothing. I visited the office of the Aetna manager of the medicare claim administration office in Portland. I was accompanied by Mrs. Walli Schneider, investigative reporter for the Oregon Journal newspaper in Portland, Oreg.

The Aetna manager, Mr. Don Stiller, was very courteous and responsive to questions posed on the medicare claim administration program.

Stiller confirmed the method of determining fair and reasonable prices, as stated by the SSA officials. In the discussion of procedures for disputes of cost denials, he stated that an Aetna employee, not an attorney, would fly to Portland from the Aetna office in Los Angeles to conduct the hearing.

It was further stated that the determination of this Aetna hearing officer was final and conclusive, with no other avenues to appeal the Aetna decisions.

During the period from June to September 1976 I found fault, in my opinion, with the method of denial of physicians and related costs.

The procedure seems to be to have some denial to every medical bill. It was learned that the great majority of the carrier's employees, who have the responsibility of examining medical bills submitted, are high school graduates.

The personnel total from 125 to 155 annually. The question of contractor capability to examine and evaluate medical statements, terminology and costs thereto is deemed highly questionable.

As a result of my in-depth involvement in many facets of the medicare program, I believe that I have acquired a better understanding of its internal problems.

I also have spoken personally with over 100 elderly citizens and believe that the fact that they have to live with this program, gives them a far greater understanding of the whys and wherefores of its defects and potential alternatives to correct.

The Oregon Journal newspaper has expressed deep concern over the problems encountered by the elderly citizens in acquiring adequate medical care.

I believe that the news coverage, by the Journal of my interest in the problems encountered by my father in his hospitalization recently are extremely well covered in the Journal article published on September 9, 1976.

I have attached a copy of this article, which you have placed already in the record, to my statement.

I believe that a recent letter from the carrier, Aetna, provides an excellent example of how a private company places the best interests of the company over the best interests of the elderly citizens.

I do not go into it here, but in this letter the insurer or the carrier was advising me in regard to a matter where they sent a check to cover three payments for three separate services instead of sending three checks they sent one and I sent it back three times and on the fourth time around I said, "Keep it; it is not going to be honored, period. I will take care of it on my own and take you into court."

The carrier came back with the statement that the cost for sending us separate checks for the carrier were prohibitive and it was felt to be the responsibility of the medicare participants, which is not the intent, I believe, of the original act.

This is shown on my attachment C.

Because of the limitation of time in this presentation, I would like to summarize my submittal as follows:

1. The preponderance of evidence that has come to my attention since I became involved in the matter reflects the dire need for a revision of the basic Medicare Act of 1965.

2. Seriously I question the agreement in existence between the insurance carrier which administers the medicare claims and the Bureau of Health Insurance at HEW.

The agreement, while basically sound and in the majority written in compliance with the Federal procurement regulations, lacks adequate monitoring authority for the Government to insure that all aspects of the so-called "best interests of the Government" are protected.

3. There should be a government program established whereby the elderly citizens can obtain advice and assistance in regard to which doctors and hospitals will accept medicare cost determinations.

Every elderly citizen I spoke to agreed that the Government should publish quarterly or annually a list of physicians who will accept medicare cost determinations as their fee.

This would allow the elderly to pay the 20-percent portion as stated in the original intent of the Medicare Act of 1965.

4. The proviso of allowing physicians to "choose" between accepting parts of medicare cost determinations was denounced by 100 percent of the people I spoke to on the subject.

The consensus was for "all or nothing at all" approach. The Medicare Claims Administration is already a tremendous headache for our elderly citizens, and to burden them with more "choices" would be totally unacceptable to the elderly citizens.

5. The Congress should bear in mind that the contract for medicare between the government and the elderly is in fact a legal contract.

That changes made unilaterally by Congress or HEW to the original intent of the Medicare Act of 1965 requires that each person be made aware of the change.

Primarily, the effects of the private insurance companies carriers who administer the medicare claims, in applying their own interpretation of the Medicare Act, that is, in regard to hearings and appeals on cost denials, raise serious questions of legal authority and liability.

A contract with Federal Government is subject to examination by the General Accounting Office, unless prohibited by an act of Congress, or other authority.

The medicare health insurance policy is a contract between the Government and the elderly citizen. The carrier is in fact a subcontractor to this contract for the government.

The question of the avenue of appeals on cost disputes is dead-ended and under control of the carrier, under part B. I believe it was not the intent of Congress to deny our elderly citizens full access to the appeal route of contract cost disputes.

I suggest that the wishes of the elderly for a more adequate hearing procedure be evaluated.

6. In the past few months I have found some evidence that there might be three "books of costs", that is:

(*a*) For insurance claims
(*b*) For Medicare claims
(*c*) For private claims

Let me advise that I did not attempt to conduct any investigation into this possibility. Several persons, whom I know personally, advised me of this matter. The potentials are very high.

The term most commonly used in these conversations was the "fraud" in multiple costs. I believe if such situations did exist, the Department of Justice would take a hard look at the possibilities, since biased costing on government contracts or agreements is in effect, commission of fraud.

One logical way to resolve this would be for an investigation by the GAO.

Now, I already requested this in another matter that will tie in with it. I got a response from GAO and Senator Packwood requested an investigation also by GAO into the medicare situation with that one.

That is it. I would like to add this: The newspaper article on medicare was printed last Thursday evening on the 9th of the month. I left Portland for St. Louis on Friday night and before I left I got a special delivery letter which I would like to read.

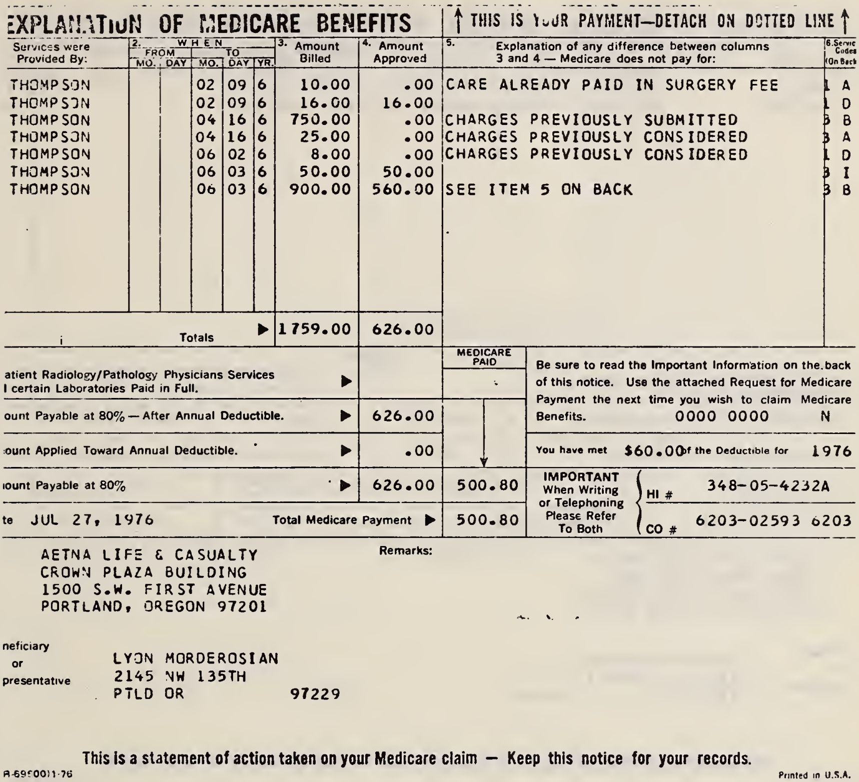
I think it says more in two written pages than I have done with nine typewritten pages. It is dated September 10, 1976.

> MY DEAR SIR: It was with the greatest interest I read the article about you and the Medicare rip-off. I, too, stand very much in the same predicament as your father. My parents came to this country from Belgium in 1970 with the same hopes your father had when he came.
>
> Now I reached 75 years I find myself completely lost. My wife went to the hospital on August 26, 1976, and was since then found to have cancer of the brain. The operation that the doctors performed have left her a helpless cripple with the loss of her right eye and paralysis of the left side.
>
> The bills have not rolled in yet, but I know they will be staggering. All I have is a savings account of $2500 and medicare plus a little pension.
>
> I am not writing this letter to ask you to help me with my bills, but the real purpose is to suggest to you the innovation of a plan, a battle plan as it were, whereby with the help you will get from the news media you might start a national battle plan which the senior citizens might contribute to a fund, say, of one dollar a month to lobby the Congress of these United States of America together with the help of younger citizens who face prospects of becoming senior citizens some day, funds sufficient to make Medicare work as it was intended to.
>
> Very sincerely yours.

He says a lot of things in a short time and I think he got many good points across.

If you have any questions or anything, I will be glad to answer them.

[Attachments to the prepared statement follow:]



EXPLANATION OF MEDICARE BENEFITS

↑ THIS IS YOUR PAYMENT—DETACH ON DOTTED LINE ↑

Services were Provided By:	2. WHEN FROM MO.	DAY	TO MO.	DAY	YR.	3. Amount Billed	4. Amount Approved	5. Explanation of any difference between columns 3 and 4 — Medicare does not pay for:	6. Service Codes (On Back)
THOMPSON			02	09	6	10.00	.00	CARE ALREADY PAID IN SURGERY FEE	1 A
THOMPSON			02	09	6	16.00	16.00		1 D
THOMPSON			04	16	6	750.00	.00	CHARGES PREVIOUSLY SUBMITTED	3 B
THOMPSON			04	16	6	25.00	.00	CHARGES PREVIOUSLY CONSIDERED	3 A
THOMPSON			06	02	6	8.00	.00	CHARGES PREVIOUSLY CONSIDERED	1 D
THOMPSON			06	03	6	50.00	50.00		3 I
THOMPSON			06	03	6	900.00	560.00	SEE ITEM 5 ON BACK	3 B
Totals ▶						1759.00	626.00		

		MEDICARE PAID
atient Radiology/Pathology Physicians Services l certain Laboratories Paid in Full. ▶		
ount Payable at 80% — After Annual Deductible. ▶	626.00	↓
ount Applied Toward Annual Deductible. ▶	.00	
ount Payable at 80% ▶	626.00	500.80
te JUL 27, 1976 — Total Medicare Payment ▶		500.80

Be sure to read the Important Information on the back of this notice. Use the attached Request for Medicare Payment the next time you wish to claim Medicare Benefits. 0000 0000 N

You have met $60.00 of the Deductible for 1976

IMPORTANT When Writing or Telephoning Please Refer To Both
HI # 348-05-4232A
CO # 6203-02593 6203

AETNA LIFE & CASUALTY
CROWN PLAZA BUILDING
1500 S.W. FIRST AVENUE
PORTLAND, OREGON 97201

Remarks:

neficiary or presentative
LYON MORDEROSIAN
2145 NW 135TH
PTLD OR 97229

This is a statement of action taken on your Medicare claim — Keep this notice for your records.

R-69500011-76

Printed in U.S.A.

XPLANATIUN OF MEDICARE BENEFITS

↑ THIS IS YOUR PAYMENT—DETACH ON DOTTED LINE ↑

Services were Provided By:	2. WHEN FROM MO.	DAY	TO MO.	DAY	YR.	3. Amount Billed	4. Amount Approved	5. Explanation of any difference between columns 3 and 4 — Medicare does not pay for:	6.Servic Codes (On Back
THOMPSON			04	16	6	25.00	25.00		3 A
THOMPSON			04	16	6	750.00	660.20	SEE ITEM 5 ON BACK	3 B
					Totals ▶	775.00	685.20		

			MEDICARE PAID
tient Radiology/Pathology Physicians Services certain Laboratories Paid in Full.	▶		
unt Payable at 80% — After Annual Deductible.	▶	685.20	
unt Applied Toward Annual Deductible.	▶	.00	
unt Payable at 80%	▶	685.20	548.16
e JUL 20, 1976	Total Medicare Payment ▶		548.16

Be sure to read the Important Information on the back of this notice. Use the attached Request for Medicare Payment the next time you wish to claim Medicare Benefits. 0000 0000 N

You have met $60.00 of the Deductible for 1976

IMPORTANT When Writing or Telephoning Please Refer To Both

HI # 348-05-4232A

CO # 6201-10046 6202

AETNA LIFE & CASUALTY
CROWN PLAZA BUILDING
1500 S.W. FIRST AVENUE
PORTLAND, OREGON 97201

Remarks:

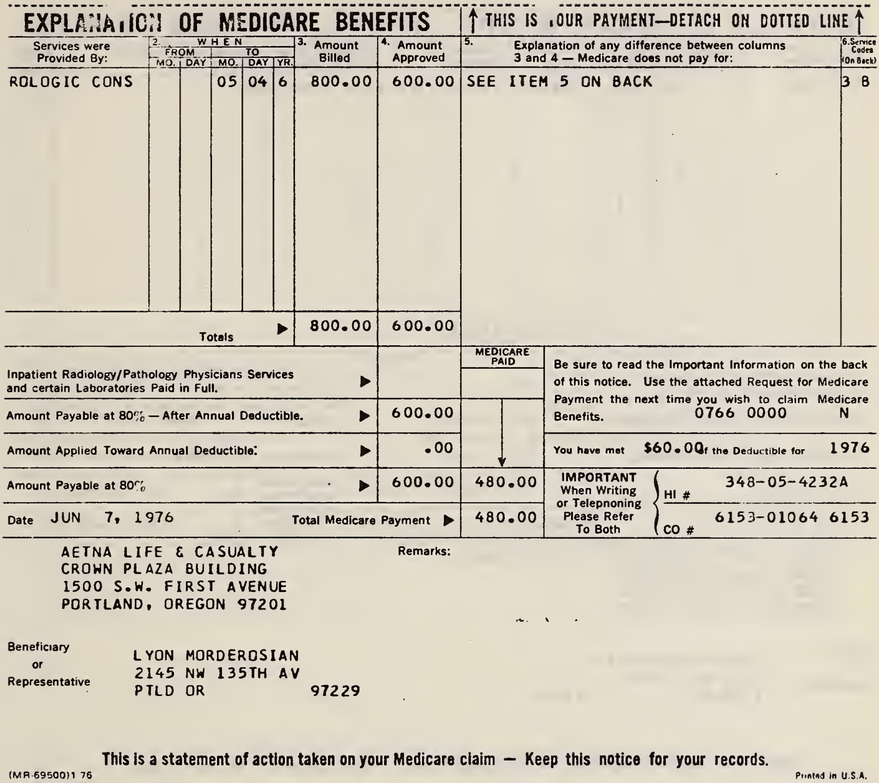
neficiary or presentative

LYON MORDEROSIAN
2145 NW 135TH AV
PTLD OR 97229

This is a statement of action taken on your Medicare claim — Keep this notice for your records.

R-69500)1-76

Printed in U.S.A.



EXPLANATION OF MEDICARE BENEFITS

↑ THIS IS YOUR PAYMENT—DETACH ON DOTTED LINE ↑

Services were Provided By:	2. WHEN FROM MO.	DAY	TO MO.	DAY	YR.	3. Amount Billed	4. Amount Approved	5. Explanation of any difference between columns 3 and 4 — Medicare does not pay for:	6. Service Codes (On Back)
ROLOGIC CONS			05	04	6	800.00	600.00	SEE ITEM 5 ON BACK	3 B
Totals ▶						800.00	600.00		

		MEDICARE PAID	
Inpatient Radiology/Pathology Physicians Services and certain Laboratories Paid in Full. ▶			Be sure to read the Important Information on the back of this notice. Use the attached Request for Medicare Payment the next time you wish to claim Medicare Benefits. 0766 0000 N
Amount Payable at 80% — After Annual Deductible. ▶	600.00	↓	
Amount Applied Toward Annual Deductible: ▶	.00		You have met $60.00 of the Deductible for 1976
Amount Payable at 80% ▶	600.00	480.00	IMPORTANT When Writing or Telepnoning Please Refer To Both — HI # 348-05-4232A
Date JUN 7, 1976 — Total Medicare Payment ▶		480.00	CO # 6153-01064 6153

AETNA LIFE & CASUALTY
CROWN PLAZA BUILDING
1500 S.W. FIRST AVENUE
PORTLAND, OREGON 97201

Remarks:

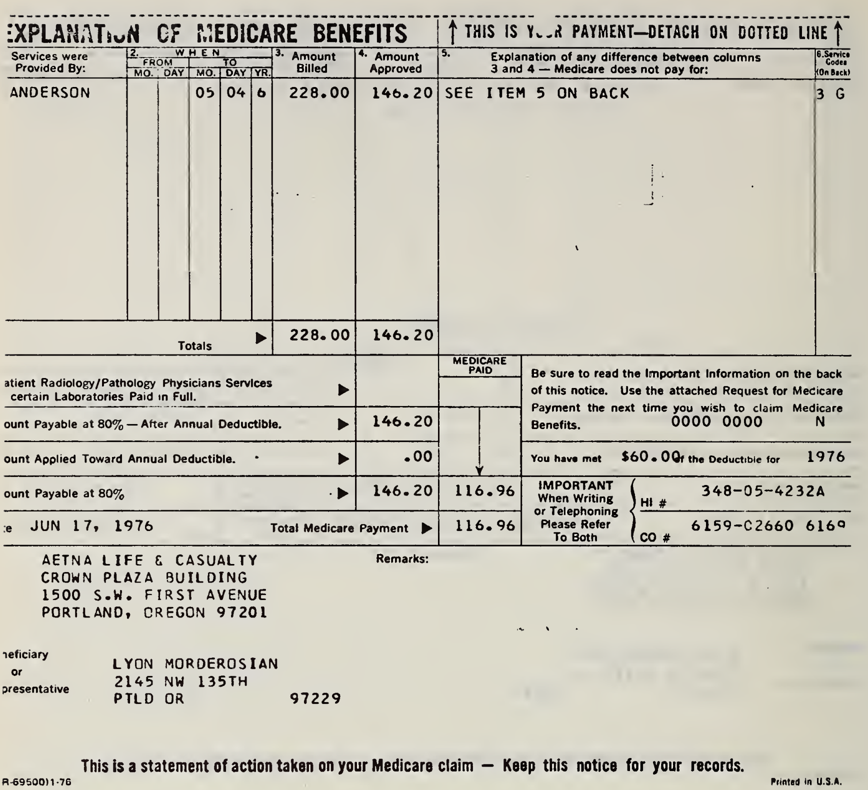
Beneficiary or Representative

LYON MORDEROSIAN
2145 NW 135TH AV
PTLD OR 97229

This is a statement of action taken on your Medicare claim — Keep this notice for your records.

(MR-69500)1 76

Printed in U.S.A.



XPLANATION OF MEDICARE BENEFITS

↑ THIS IS YOUR PAYMENT—DETACH ON DOTTED LINE ↑

Services were Provided By:	2. WHEN FROM MO.	DAY	TO MO.	DAY	YR.	3. Amount Billed	4. Amount Approved	5. Explanation of any difference between columns 3 and 4 — Medicare does not pay for:	6. Service Codes (On Back)
ANDERSON			05	04	6	228.00	146.20	SEE ITEM 5 ON BACK	3 G
Totals ▶						228.00	146.20		

		MEDICARE PAID	
atient Radiology/Pathology Physicians Services certain Laboratories Paid in Full. ▶			Be sure to read the Important Information on the back of this notice. Use the attached Request for Medicare Payment the next time you wish to claim Medicare Benefits. 0000 0000 N
ount Payable at 80% — After Annual Deductible. ▶	146.20		
ount Applied Toward Annual Deductible. ▶	.00		You have met $60.00 of the Deductible for 1976
ount Payable at 80% ▶	146.20	116.96	IMPORTANT When Writing or Telephoning Please Refer To Both HI # 348-05-4232A
e JUN 17, 1976 Total Medicare Payment ▶		116.96	CO # 6159-C2660 616

AETNA LIFE & CASUALTY
CROWN PLAZA BUILDING
1500 S.W. FIRST AVENUE
PORTLAND, OREGON 97201

Remarks:

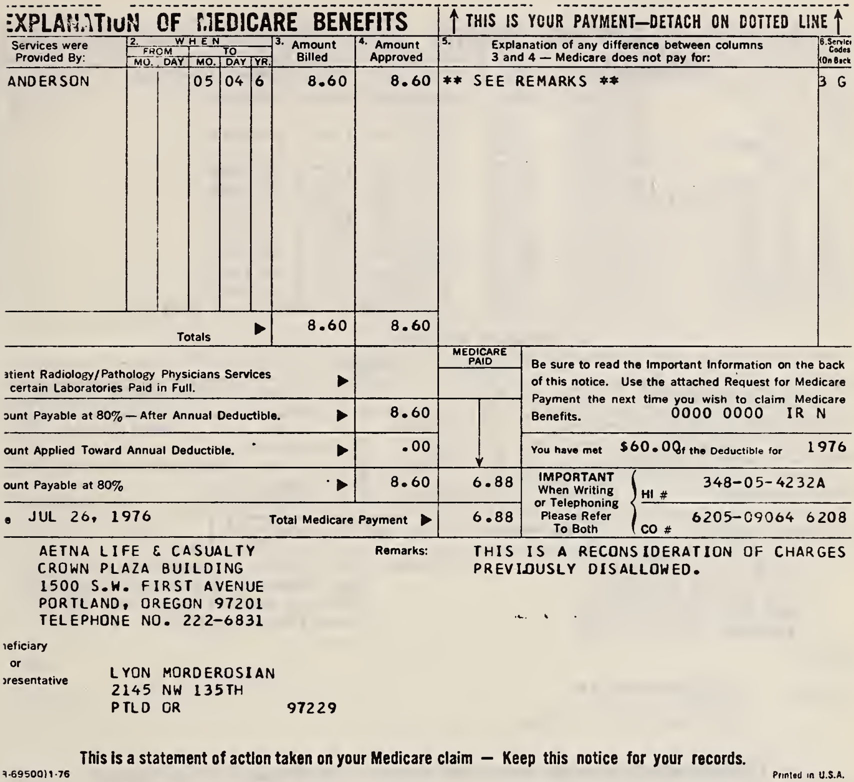
neficiary or presentative

LYON MORDEROSIAN
2145 NW 135TH
PTLD OR 97229

This is a statement of action taken on your Medicare claim — Keep this notice for your records.

R-6950011-76

Printed in U.S.A.



EXPLANATION OF MEDICARE BENEFITS

↑ THIS IS YOUR PAYMENT—DETACH ON DOTTED LINE ↑

Services were Provided By:	2. WHEN FROM MO.	DAY	TO MO.	DAY	YR.	3. Amount Billed	4. Amount Approved	5. Explanation of any difference between columns 3 and 4 — Medicare does not pay for:	6. Service Codes (On Back
ANDERSON			05	04	6	8.60	8.60	** SEE REMARKS **	3 G
Totals ▶						8.60	8.60		

		MEDICARE PAID
atient Radiology/Pathology Physicians Services certain Laboratories Paid in Full. ▶		
ount Payable at 80% — After Annual Deductible. ▶	8.60	↓
ount Applied Toward Annual Deductible. ▶	.00	↓
ount Payable at 80% ▶	8.60	6.88
e JUL 26, 1976 Total Medicare Payment ▶		6.88

Be sure to read the Important Information on the back of this notice. Use the attached Request for Medicare Payment the next time you wish to claim Medicare Benefits. 0000 0000 IR N

You have met $60.00 of the Deductible for 1976

IMPORTANT When Writing or Telephoning Please Refer To Both

HI # 348-05-4232A

CO # 6205-09064 6208

AETNA LIFE & CASUALTY
CROWN PLAZA BUILDING
1500 S.W. FIRST AVENUE
PORTLAND, OREGON 97201
TELEPHONE NO. 222-6831

Remarks: THIS IS A RECONSIDERATION OF CHARGES PREVIOUSLY DISALLOWED.

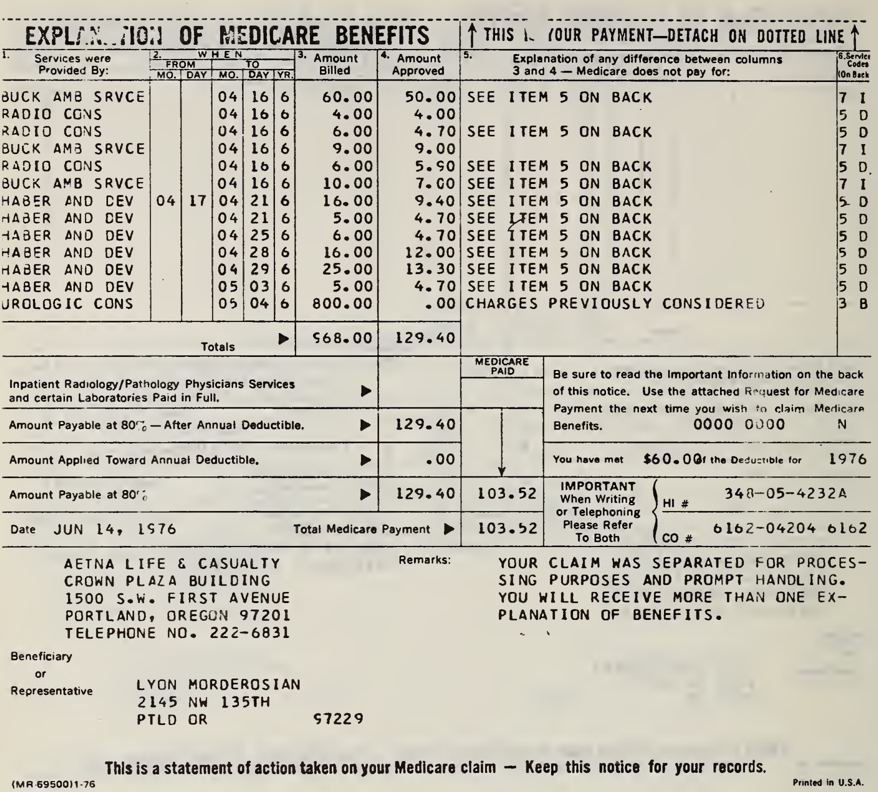
ieficiary or presentative

LYON MORDEROSIAN
2145 NW 135TH
PTLD OR 97229

This is a statement of action taken on your Medicare claim — Keep this notice for your records.

3-6950011-76

Printed in U.S.A.



EXPLANATION OF MEDICARE BENEFITS

↑ THIS IS YOUR PAYMENT—DETACH ON DOTTED LINE ↑

1. Services were Provided By:	2. WHEN FROM MO.	DAY	TO MO.	DAY	YR.	3. Amount Billed	4. Amount Approved	5. Explanation of any difference between columns 3 and 4 — Medicare does not pay for:	6. Service Codes (On Back)
BUCK AMB SRVCE			04	16	6	60.00	50.00	SEE ITEM 5 ON BACK	7 I
RADIO CONS			04	16	6	4.00	4.00		5 D
RADIO CONS			04	16	6	6.00	4.70	SEE ITEM 5 ON BACK	5 D
BUCK AMB SRVCE			04	16	6	9.00	9.00		7 I
RADIO CONS			04	16	6	6.00	5.90	SEE ITEM 5 ON BACK	5 D
BUCK AMB SRVCE			04	16	6	10.00	7.00	SEE ITEM 5 ON BACK	7 I
HABER AND DEV	04	17	04	21	6	16.00	9.40	SEE ITEM 5 ON BACK	5 D
HABER AND DEV			04	21	6	5.00	4.70	SEE ITEM 5 ON BACK	5 D
HABER AND DEV			04	25	6	6.00	4.70	SEE ITEM 5 ON BACK	5 D
HABER AND DEV			04	28	6	16.00	12.00	SEE ITEM 5 ON BACK	5 D
HABER AND DEV			04	29	6	25.00	13.30	SEE ITEM 5 ON BACK	5 D
HABER AND DEV			05	03	6	5.00	4.70	SEE ITEM 5 ON BACK	5 D
UROLOGIC CONS			05	04	6	800.00	.00	CHARGES PREVIOUSLY CONSIDERED	3 B
Totals ▶						968.00	129.40		

		MEDICARE PAID	
Inpatient Radiology/Pathology Physicians Services and certain Laboratories Paid in Full. ▶			Be sure to read the Important Information on the back of this notice. Use the attached Request for Medicare Payment the next time you wish to claim Medicare Benefits. 0000 0000 N
Amount Payable at 80% — After Annual Deductible. ▶	129.40	↓	
Amount Applied Toward Annual Deductible. ▶	.00		You have met $60.00 of the Deductible for 1976
Amount Payable at 80% ▶	129.40	103.52	IMPORTANT When Writing or Telephoning Please Refer To Both: HI # 348-05-4232A
Date JUN 14, 1976 Total Medicare Payment ▶		103.52	CO # 6162-04204 6162

AETNA LIFE & CASUALTY
CROWN PLAZA BUILDING
1500 S.W. FIRST AVENUE
PORTLAND, OREGON 97201
TELEPHONE NO. 222-6831

Remarks: YOUR CLAIM WAS SEPARATED FOR PROCESSING PURPOSES AND PROMPT HANDLING. YOU WILL RECEIVE MORE THAN ONE EXPLANATION OF BENEFITS.

Beneficiary or Representative

LYON MORDEROSIAN
2145 NW 135TH
PTLD OR 97229

This is a statement of action taken on your Medicare claim — Keep this notice for your records.

(MR 69500)1-76

Printed in U.S.A.

:XPLANATI N OF MEDICARE BENEFITS

↑ THIS IS YOUR PAYMENT—DETACH ON DOTTED LINE ↑

Services were Provided By:	2. WHEN FROM MO.	DAY	TO MO.	DAY	YR.	3. Amount Billed	4. Amount Approved	5. Explanation of any difference between columns 3 and 4 — Medicare does not pay for:	6. Service Codes (On Back)
LANDREY			06	15	6	44.00	30.00	SEE ITEM 5 ON BACK	3 C
Totals ▶						44.00	30.00		

		MEDICARE PAID	
tient Radiology/Pathology Physicians Services certain Laboratories Paid in Full. ▶			Be sure to read the Important Information on the back of this notice. Use the attached Request for Medicare Payment the next time you wish to claim Medicare Benefits. 0000 0000 N
unt Payable at 80% — After Annual Deductible. ▶	30.00		
unt Applied Toward Annual Deductible. ▶	.00		You have met $60.00 of the Deductible for 1976
unt Payable at 80% ▶	30.00	24.00	IMPORTANT When Writing or Telephoning Please Refer To Both — HI # 348-05-4232A
AUG 18, 1976 — Total Medicare Payment ▶		24.00	CO # 6230-00172 6231

AETNA LIFE & CASUALTY
CROWN PLAZA BUILDING
1500 S.W. FIRST AVENUE
PORTLAND, OREGON 97201

Remarks:

eficiary or resentative

LYON MORDEROSIAN
2145 NW 135TH AV
PTLD OR 97229

This is a statement of action taken on your Medicare claim — Keep this notice for your records.

-69500)1-76

Printed in U.S.A.

ALWAYS GIVE YOUR HEALTH INSURANCE CLAIM NUMBER WHEN WRITING ABOUT YOUR CLAIM.

BRING THIS NOTICE WITH YOU IF YOU INQUIRE AT A SOCIAL SECURITY OFFICE.

1. IMPORTANT—YOU CAN USE THIS NOTICE:
   - a. To show your physician or supplier how much of the annual deductible you have met as of the date of this notice.
   - b. As a record of bills paid or denied. (If you sent in other medical expenses not shown on this form, you will get a separate notice.)
   - c. To collect other insurance. If you have other health insurance, you may use this notice to claim the benefits from your private insurance policy. Since your private insurance company may keep this notice, you may wish to keep a record of this information or ask your insurance company for a photocopy.

2. IF YOU NEED MORE INFORMATION:
   - a. Check your Medicare Handbook;
   - b. Contact a Social Security Office; or
   - c. Contact the Aetna Life & Casualty Office indicated on the front.

3. TIME LIMIT FOR FILING CLAIMS:

For Services Received	File Claim By
Oct 1, 1973 - Sept. 30, 1974	Dec. 31, 1975
Oct. 1, 1974 - Sept. 30, 1975	Dec. 31, 1976
Oct. 1, 1975 - Sept. 30, 1976	Dec. 31, 1977
Oct 1, 1976 - Sept. 30, 1977	Dec. 31, 1978

When a person could not file his claim within these limits because of an error or delay of the Social Security Administration or of a Medicare carrier intermediary, these limits do not apply.

4. HOW MUCH DOES MEDICARE PAY?

Medicare pays 80% of the charges in Column 4 above the annual deductible. The annual deductible is now $60. For calendar years before 1973 it was $50.

Medicare pays 100% of the charges in Column 4 for radiology and pathology services from a physician while you are a bed patient in a qualified hospital.

Medicare also pays 100% of the charges in column 4 for laboratory services if the laboratory has agreed to accept a negotiated rate as payment in full.

5. IF PAYMENT NOT BASED ON FULL AMOUNT BILLED

The amount Medicare may pay under law is limited to the lowest of:
   - a. Customary charge, i.e., the charge made by the physician or supplier in 50% of his billing during the base year.
   - b. Prevailing charge, i.e., the charge made 75% of the time by other physicians or suppliers for similar services in the area during the base year.
   - c. The amount permitted under the limits established by the Cost of Living Council.

6. YOUR RIGHT TO REVIEW OF THE CASE

If you have a problem or question about the way your claim was handled or about the amount paid, please get in touch with the Aetna Life & Casualty Office indicated on the front within 6 months of the date of this notice.

The Social Security Office will help you file a request for review of your claim if it is more convenient.

CODES FOR PLACE AND TYPE OF SERVICE

PLACE OF SERVICE

1. Office
2. Home
3. Inpatient Hospital
4. Skilled Nursing Facility
5. Outpatient Hospital
6. Independent Laboratory
7. Other
8. Nursing Home
9. Independent Kidney Disease Treatment Centers

TYPE OF SERVICE

A. Medical Care
B. Surgery (Includes Treatment of Fractures)
C. Consultation
D. Diagnostic X-Rays
E. Diagnostic Laboratory
F. Radiation Therapy
G. Anesthesia
H. Assistance at surgery
I. Other medical service
J. Whole blood and packed red blood cells

THURSDAY OREGON Journal 15¢
Final Edition
Portland, Oregon, Thursday, September 9, 1976

Beaverton Man Hits Medicare 'Ripoff'

By WALLI SCHNEIDER
Journal Staff Writer

Larry Morderosian, 51, may feel a bit like the Biblical David marching off to meet Goliath with only a sling shot.

The tall, dark haired, outspoken Armenian goes into battle Wednesday in Washington, D.C., against Medicare, the multibillion dollar giant that has purported since 1966 to protect elderly citizens from the morass of medical bills and allow them proper physical care in the years they need it most.

Morderosian isn't poor.

He is taking his complaints to the House Ways and Means subcommittee on Health, which is holding hearings on Medicare physician reimbursement, on behalf of his 85-year-old father, Lyon Morderosian.

The medical bills he will speak about are meager in contrast to the bills that beset many senior citizens struck with catastrophic illness.

They total only $12,000.

But Morderosian has the tenacity of a watchdog.

He also has the expertise — 25 years as a contract official with the military, the federal government and private enterprise. He presently is construction contracting officer for Bonneville Power Administration and assistant to the construction and services manager.

Add to that a portfolio that Morderosian has amassed over the past four months.

Approximately five inches thick, it's stuffed with letters from supporting physicians, from Oregon Sens. Mark Hatfield and Bob Packwood and Idaho Sen. Frank Church, from the Department of Health, Education and Welfare and with missives from the Social Security Administration and Aetna Life & Casualty Co.

"My understanding — and I'm sure that of hundreds of thousands of other people — was that elderly patients pay only approximately 20 per cent of their bills for medical care and that the government, through Medicare, picks up about 80 per cent," says Morderosian.

"I found, in reality, that the older person pays more like 47 per cent. They are being ripped off. They are being neglected. I'm disgusted and I damn well plan to do something about it for every older person in the United States."

Medicare might never have entered Morderosian's mind were it not for his 85-year old father and 71-year-old mother, both of whom share his posh Beaverton-area home with him and his daughter, Kim, 10.

Lyon Morderosian fell on April 4, 1976 breaking his left hip. He spent 29 days in the hospital, returned for a subsequent stay and had a total of three surgeries.

Including ambulances, hospital care, surgeons, radiologists and urologic consultants, he ended up with a final bill in excess of $12,000.

A startled and eventually confused senior citizen, the older Morderosian finally received less than 58 per cent of that total bill from Medicare.

His son wasn't just startled. He returned all the checks he received through Medicare via Aetna Life & Casualty, charging that, "As far as I am

(Continued on Page 2)

2 Oregon Journal, Thursday, September 9, 1976 (2)

Medicare 'Ripoff' Lambasted

(Continued from Page 1)

concerned, this is a violation of the health insurance contract between my father and the Social Security Administration.

He began getting in touch with senators and representatives, Social Security administrators and insurance executives. He sent letters, telegrams and documents. He made countless telephone calls and capped his search by flying to Baltimore to obtain a copy of the original Medicare agreement from the Bureau of Health Insurance of the Social Security Administration.

"I just won't give up," he told The Journal. "The intent of Congress in passing the Medicare bill was to protect older people. The intent is not being followed. My parents came from the old country (his father came from a city that is now Van, Turkey, and his mother from Salinas, Rumania).

"To them the United States was a new country, a new hope," he said. "But it's the same here. The rich get rich and the poor get poorer."

First, he says, he will challenge the very Medicare contract because "it is made between the government and a private insurance firm (in Portland's case, Aetna Life & Casualty) and not between the government and an individual, as people are led to believe."

Secondly, Morderosian claims, private firms such as Aetna not only make major determinations on claims but also sell supplementary insurance policies to Medicare clients.

"Medicare tells me that the amount they must pay under law is the lowest of three things," Morderosian muses. "And believe me, that can be low.

The items include:

- The customary charge: "That charge made by the physician or supplier in 50 per cent of his billing during the base year.
- The prevailing charge: "The charge made 75 per cent of the time by other physicians or suppliers for similar services in the area during the base year."
- The amount permitted under the limits established by the Cost of Living Council.

"Who in his right mind would even know what the 'prevailing charge' or 'customary charge' or 'permitted charge' is?" Morderosian demands.

"My parents certainly wouldn't know.

"They also wouldn't be able to pay unless I was here," he said. "They'd have to declare bankruptcy. Who do you know at their age who can even afford to get sick?"

Morderosian will testify at 9 a.m. Wednesday in the Main Committee Office Building in Washington, D.C.

ALL IN FAMILY — Medicare, multibillion dollar program to help elderly with medical bills, is taking lambasting from Portland area family, including Larry Morderosian, right, contracting officer for Bonneville Power Administration. Morderosian will contest Medicare policies in Washington, D.C., this month on behalf of his 85-year old father, Lyon Morderosian, center. Mrs. Morderosian and Larry's daughter, Kim, 10, are supportive of all-out effort to change Medicare for 23 million elderly.

Plan For Better Medicare

Larry Morderosian will present the following 10 point plan for a better health contract for the elderly to the House Ways and Means Committee's Subcommittee on Health, at the invitation of Rep. Al Ullman, committee chairman:

- That the federal government publish a list of doctors who agree to accept Medicare reimbursements as 80 per cent of their cost billings to Medicare participants.
- That the federal government publish a list of prices (payments) that are acceptable for Medicare's 80 per cent obligation payment.
- That the Department of Health, Education and Welfare administer the Medicare program itself and that the delegation of contract administration of Medicare by private insurance companies (carriers) be revoked in full.
- That the Medicare program be automatically (and annually) subject to total audit by the U.S. General Accounting Office.
- That Congress amend the Social Security Amendments of 1965 (Medicare Act) to the extent of revoking the legal authority of agents (insurance subcontractors) to have control over disbursements and complete authority to conduct hearings on complaints of Medicare participants.

"All hearings on complaints should be conducted by federal solicitors, either assigned to HEW or another special judicial authority established by and subject only to Congress," Morderosian maintains.

- That if the present insurance company (carrier) system is allowed to continue, then public accounting through the news media be made for the full operational costs and all costs of the Medicare program.
- That a public agency, independent of HEW or Social Security, be established by Congress to provide advice to the elderly on questions about Medicare and Medicaid.
- That elderly citizens become members of a panel established by Congress in order to have a firm voice in Medicare administration.
- That physicians might be allowed tax deductions for offering lower costs to Medicare patients.
- That Congress should pass a national health insurance program if it cannot control or solve the Medicare and Medicaid crises.

Morderosian asks that any comment on the proposals be sent to him at 2145 NW 115th Ave., Portland 97229.

PORTLAND, OREG., *September 5, 1976.*

Re: Lyon (NMI) Morderosian, MHP #348 05 2423a.

AETNA LIFE AND CASUALTY CO.,
MEDICARE CLAIM ADMINISTRATION,
Attn: Ms. D. BREWSTER, *Claim Analyst,*
Portland, Oreg.

DEAR MS. BREWSTER: Reference is made to your letter dated September 1, 1976, subject as cited above.

I have forwarded the check for $9.36 to the offices of Drs. Haber & Devine as you advised.

In the matter of the check for three separate billing offices, I decline to accept as valid your explanation for this type of action. I fail to agree that the Medicare patient has the responsibility of dividing up any combination of payments for several doctors, and having to go to a Post Office or Bank and make out money orders or checks to pay them. I have conducted research of the agreement between the Aetna and SSA, as well as the PL 89–97, Medicare Acts, etc., and fail to find any legal requirement for this action by your office. If anything, your explanation serves as excellent fuel for refusing to accept this type of Administrative Overhead saving for Aetna. As far as I am concerned, it is the legal responsibility of Aetna to send separate checks for each billing office. If you decline to accept that obligation, I am forced to refuse to accept this check and ask that you so mark my father's file. I will then take the matter up with the Director of the BHI, and/or GAO. I believe that your interpretation of the Medicare Law needs some evaluation. The intent of the Medicare Law was to aid the elderly, not to make the situation become intolerable. My father, and many millions of the elderly citizens, have never been able to understand the legal maneuvering by Aetna or any other Carrier. Let me carry it a step further. He has no checking account and never has had one. He cannot walk for at least another few months, and your claim that he should take care of breaking down this check is ridiculous. Is he expected to take a cab to the nearest bank or Post Office, make out checks, and mail them? Place any Medicare patient in this position, and you might see what I am trying to say. I have no intention of being a party to such actions.

My advice to any Medicare participants will follow this line of reasoning, and I can assure you that on September 15, 1976, when I testify before the U.S. Congress on the Medicare hearings, I will be happy to use your letter as a sample of the problems that elderly people have to cope with to pay their bills under the present Medicare program. This is not intended to embarrass you. I have many such examples to present at this hearing.

Sincerely,

LAWRENCE D. MORDEROSIAN.

MEDICARE CLAIM ADMINISTRATION,
Portland, Oreg., September 1, 1976.

Re: Lyon Morderosian, HIC NO: 348–05–4232A.

LAWRENCE D. MORDEROSIAN,
Portland, Oreg.

DEAR MR. MORDEROSIAN: This will respond to your letter of inquiry directed to Mr. Stiller dated August 19, 1976 on behalf of your father. Your inquiry requested identification of the enclosed payment of $9.36, and multiple checks for the enclosed payment of $103.52.

The $9.36 payment is an additional payment for services rendered by Drs. Haber and Devine on 4/29/76 as explained to you in our previous correspondence dated July 2, 1976.

You have asked that we reissue your father's check for $103.52, making a single check for each separate physician. We are unable to accommodate your request. The purpose of the Medicare Law was to substantially reduce the financial burden of medical costs for the elderly, while at the same time it was not designed to substantially increase costs to the taxpayer.

Generally speaking, the cost of processing Medicare claims ranges from $1.00 to $10.00 per claim. If, we processed each bill individually that was submitted as one claim, as you request, the taxpayers cost would increase from $1.00 to $10.00 to $3.00 to $30.000 per bill. This is not a fair burden to place on anyone, thus the Bureau of Health Insurance regulations require that all bills submitted with one claim form, unassigned, be combined into one claim.

Enclosed are the checks you returned to this office. The Explanation of Medicare Benefits form fully identifies the provider and the fees submitted as well as the allowed charges.

In the future you may wish to submit non-assigned claims separately with all billings from one provider attached to one Request for Medicare Payment form.

Sincerely,

D. Brewster, *Claim Analyst.*

Enclosure.

Portland, Oreg., *September 10, 1976.*

Mr. Larry Morderosian.

My Dear Sir: It was with the greatest interest that I read the article about you and the medicare rip-off. I too stand very much in the same predicament as your father. My parents and I came to this country from Belgium in 1920 with the same hopes your father had when he came here. Now that I have reached my 75th year, I find myself completely lost. My wife went to the hospital on 8–15–76 and since then has been found to have cancer of the brain. The operation the doctors have performed has left her a helpless cripple. The loss of her right eye and paralized left side. The bills haven't started to roll in yet, but I know they will be staggering. All I have is a saving of about $2,500 and medicare plus a little pension.

I am not writing you this letter to ask you to help me with my bills. My real purpose is to suggest to you the innovation of a plan; a battle plan as it were, whereby with the help that you are going to get from the news media, you might start a national battle plan in which every senior citizen might contribute $1.00 per month to create a fund to lobby the Congress of these great United States of America; together with the help of all the younger citizens, who face the prospect of becoming senior citizens some day. A fund sufficient enough to make medicare work as it was intended to.

Very sincerely yours and may God Bless You,

______ ______.

Mr. Rostenkowski. Mr. Morderosian, we appreciate the fact that you bought this to our attention and certainly the committee in its deliberations will look carefully at your comments.

Mr. Duncan. I have no questions, but I do want to thank you for coming here.

We appreciate it.

Mr. Morderosian. I think if you have time to look at the newspaper article, you will notice in the second paragraph it starts off by saying that Larry Morderosian is a tall, outspoken Armenian, which I am. It goes all the way.

Thank you.

Mr. Rostenkowski. Thank you.

STATEMENT OF ROBERT J. KENNETH, KENNETH ASSOCIATES, SAN FRANCISCO, CALIF.

Mr. Rostenkowski. Mr. Kenneth, welcome to the committee, and if you will identify yourself and proceed with your testimony.

Mr. Kenneth. Thank you.

Mr. Chairman, and members of the subcommittee. My name is Robert J. Kenneth. I am the President of Kenneth Associates, a leader in the field of health facilities business management. Our headquarters are in San Francisco, Calif.

My written statement has been submitted for the record in the prescribed manner and I would like my oral comments to be considered individually.

Mr. Rostenkowski. Yes. Proceed.

Mr. Kenneth. My primary concern is with section 26 of S. 3205, the Talmadge bill, which will prohibit assignment of medicare part B and medicaid payments. I believe that assignments can be helpful to providers in solving their very real cash flow problems.

I will state and rebut the arguments in favor of section 26 as it now stands. The reason for prohibition of certain assignments in previous legislation was concern about fraudulent practices. I will demonstrate that the opportunity for fraud is a function of the degree of auditing integrity, and is not related to the assignability of accounts. The proposed bill's solution to cash flow problems—mandated 30 day payment under medicaid—in my view will just not work.

I proposed alternative amendments which will allow assignments of these accounts, but which incorporate safeguards to satisfy the Government's interest.

Assignment and factoring of accounts receivable have been common business practices in virtually all industries for many years. They enable a business to improve its cash flow, and place the billing and collection efforts in the hands of specialists.

Despite obvious economic advantages, section 26 suggests five arguments against assignment of accounts.

1. Assignments present an opportunity for greater fraud and abuse, by way of incorrect and inflated claims.

2. Assignments create an additional cost to the provider, which is indirectly passed on to the programs.

3. Assignments create additional administrative problems, principally in the area of recovery of overpayments.

4. Providers can borrow against their medicare and medicaid receivables anyway, without resort to outright asssignment of claims.

5. The proper solution to the provider's desire for prompt payment lies in improved processing by the intermediaries.

These five arguments are rebutted as follows:

Against argument 1. There is no increased opportunity for fraud attributable solely to the allowance of assignments.

The prevention of fraud in medicare and medicaid billings is no different from any other type of crime prevention—the potentially dishonest party has to be aware that he or she has a good chance of being caught, and that the penalty will be severe enough to make the attempt unwise. This requires sound auditing theory and design, plus communications to all involved parties about the effectiveness of the system, and the penalties for violation.

My written statement contains detailed suggestions on the necessary audit measures.

The important point here is that these procedures would not be any different for a provider of service who assigns accounts receivable than for one that does not assign.

Against argument 2. Program costs are decreased, not increased, if assignments are used.

The second reason for the denial of assignments, that the programs would pay additional costs, is patently false.

If the provider determines that assignment is financially advantageous, it is obvious that the cost to the government programs will also be proportionately less. Experienced assignees are specialized, and can do a more efficient job of billing than providers of service. The assignee's charge is counterbalanced by these efficiencies.

The language in section 26 infers that a problem is created by an assignee charging in proportion to the amount billed. This manner of charge is common business practice. Presumably, the provider is financially advantageous.

I'll illustrate the factors that go into this cost calculus, by reference to the typical service which my organization provides. Our objective is to increase hospital cash flow. Specifically, Kenneth Associates assists hospitals in developing improved procedures for the submission of claims.

Our success has been outstanding. For example, since 19972, we have recovered $20,000,000 for San Francisco General Hospital, at a cost to the hospital of about 1½ percent.

Our customary fee for billing services is conditional upon successful collection. Our motivation is absolute.

The cost to providers, in terms of delay in receiving payment from intermediaries is very real, and is already being passed on to the patients. The issue to be decided is which cost is greater. In my view, this decision should be left to each provider to be made in view of his own immediate economic realities.

Against argument 3. Any increase in administrative problems will be minor.

Specific problems mentioned in the committee reports were those related to "determination of reasonable charges and recovery of overpayments."

Recovery of overpayments is not affected by whether the overpayments were made to the provider, or to an assignee. Essentially, the government's ability to recover overpayments will always depend upon its auditing control over the provider. For example, the government has the threat of disqualifying the provider from participation in the programs. This implied threat would receive instant attention.

The important point here, once again, is that the government's remedies are the same whether overpayments are made to a provider or an assignee.

Against argument 4. Alternative security devices are not as effective.

This argument states that providers can borrow against their Medicare and Medicaid accounts receivable, by means other than outright assignments.

Although some devices do provide potential for borrowing, they do not provide the near-perfect security of an assignment, hence, they entail either lower loan proceeds, or, higher interest rates than would otherwise be the case.

There is one key fact in this debate worthy of special emphasis. All of the services discussed, and all of the potential abuses will continue to exist, even if assignments are prohibited. That is, submission of claims by an agent will be carried out without the use of an assignment as a security device. The difference that section 26 will make is that more legitimate agents and banks will be deterred.

Against argument 5. Streamlined processing by the government is not a feasible solution.

Section 4(a) of S. 3205, attempts to mandate that State medicaid programs establish procedures which assure that 95 percent of claims be paid within 30 days of receipt, and 99 percent within 90 days.

My experience with the medicaid program in California leads me to believe that this 30 day target is impractical and infeasible.

On the average, claims are paid by medicaid after about 60 days. This has been the average for several years. Since 1965, California has had a requirement between the State and its fiscal intermediaries, that payments are to be made within 30 days from receipt of documentation. This requirement has never been consistently met in my experience. In fact, a 1972 amendment provided that notice must be given to the provider within 60 days if the bill is "held for peer review" beyond 30 days. Even this loophole in the statute has not been complied with, although the penalty for noncompliance was termination of the contract.

I suggest hat there are serious problems arising from the nature of medicare and medicaid claims processing, which cannot simply be legislated out of existence.

In summary, section 26 of S. 3205 should not be enacted as it now stands. The arguments in favor of this proposal, which focus upon frauds and programs costs, do not take into account the benefits arising from the use of the security device. I submit that:

1. There will be no increased opportunity for fraud attributable solely to the allowance of assignment, because the requisite audit procedures will more easily detect fraud by an assignee than fraud by a provider.
2. Program costs will necessarily be decreased, not increased, if an assignment is used to secure payment by the provider, because the provider will choose the more economical arrangement.
3. Any increase in administrative problems will be minor.
4. Alternative security devices will not be as effective.
5. Streamlined processing by the Government is not a feasible solution.

Furthermore, I urge Congress to adopt the alternative amendments included in my written statement which will clarify existing law, and expressly allow assignment of provider accounts, subject to safeguards to protect the Government's interest.

Thank you.

[The prepared statement follows:]

STATEMENT OF ROBERT J. KENNETH, PRESIDENT, KENNETH ASSOCIATES, SAN FRANCISCO, CALIF.

SUMMARY

Section 26 of S. 3205, which will prohibit assignment of payments to providers, should not be enacted as it stands. The arguments in favor of this proposal, which focus upon resulting frauds and program costs, do not properly take into account the marginal benefit and costs arising from the use of this security device. I respectfully submit that:

(1) There will be no increased opportunity for fraud attributable solely to the allowance of assignment, because the requisite audit procedures will more easily detect fraud by an assignee than fraud by a provider.

(2) Program costs will necessarily be decreased, not increased, if an assignment is used to secure payment by the provider, because the provider will choose the more economical arrangement.

(3) Any increase in administrative problems will be minor.

(4) Alternative security devices will not be as effective.

(5) Streamlined processing by the government is not a feasible solution.

Furthermore, I urge Congress to adopt the alternative amendments included herein which will clarify existing law and expressly allow assignment of provider accounts subject to safeguards to protect the government's interest in the ease of administration of an assignment system.

INTRODUCTION

Mr. Chairman and members of the Subcommittee: My name is Robert J. Kenneth. I am the President of Kenneth Associates, the leading firm in the San Francisco Bay Area in the field of hospital business office management. My office is located at 1704 Irving Street, San Francisco, California 94122.

The views on S. 3205 expressed herein are based upon extensive experience working with providers in the Medicare and Medicaid programs, including twenty-four hospitals, which utilize our services in connection wtih processing and collecting their accounts receivable.

My primary concern is with Section 26 of S. 3205, which will prohibit assignments of Medicare Part B and Medicaid payments, except in connection with the provision of billing services for a fee not related to the amount of billings or collections and not dependent upon actual collection. The effect of this change will be to prohibit use of an assignment or power of attorney (which are in essence security devices) in connection with loans against provider accounts, outright purchase of such accounts ("factoring"), or the provision of billing serivces under an incentive fee arrangement. I believe, in light of my experience and contacts with providers, that all of these can be beneficial services to providers in solving their very real cash flow problems and that the greater security of the agent or lender provided by an assignment can only lower the cost of these services to the provider.

My presentation first analyzes and rebuts the arguments in favor of enactment of Section 26 as it stands. The key reason for the prohibition of certain assignments in previous legislation (Public Law 92–603 of 1972) was concern about whether assignment contributes to fraudulent practices in billing for program services; it will be demonstrated that the opportunity for fraud is a function of the degree of auditing integrity and is not related to the assignability of accounts. Similarly, other supposed problems such as added costs and recovery of overpayments will be shown to either be imaginary or to arise from causes other than the allowance of assignment. Furthermore, the proposed bill's solution to these cash flow problems—mandated 30 day payment under Medicaid—in my view will not work.

Even apart from the proposed changes, there is a need to clarify existing law. I propose herein alternative amendments which will expressly allow assignments of Medicare and Medicaid accounts, but which incorporate safeguards to satisfy the government's interest in ease of administration of assignments by providers.

I respectfully urge that Section 26 not be enacted as it stands and that serious consideration be given to the advantages provided by assignments and to passage of amendments along the lines herein proposed.

SECTION 26 OF S. 3205 SHOULD NOT BE ADOPTED

The original Medicare and Medicaid laws (Public Law 89–97 of 1965) did not prohibit assignments and in fact assignments were accepted in the programs until 1972. In that year, amendments to Medicare Part B and Medicaid were adopted (Public Law 92–603) which prohibited payments to "anyone other than" providers of services. The legislative history indicates that this prohibition of assignments did not apply to payments "based on the reasonable cost of the services" of a provider. These aspects of existing law are discussed more fully hereinafter.

Section 26 represents a more precise attempt than was evident in the 1972 amendments to prohibit factoring. It will amend the same two subsections which were amended in 1972 (Social Security Act §§ 1842(b)(5), 1902(a)(32), 42 U.S.C. §§ 1395u(b)(5), 1396(a)(32)) by adding to each a sentence which expressly bans the use of assignments and powers of attorney in relation to program payments, while at the same time creating an exception for assignments in connection with provision of billing and/or collection services for a fee that is not related to the amount of the billing and is not dependent upon actual collection. Thus, the section changes existing law by shifting the focus of the exception from the reasonableness of the provider's charges to that of the agent's charges. As the following discussion will make clear, both attempts were based upon erroneous analysis of the problems and solutions in the area of the providers' need for prompt reimbursement of claims.

Assignment and factoring of accounts receivable have been common business practices in virtually all industries for many years. They enable a business to improve its cash flow (thus reducing interest expense) and place the billing and collection efforts in the hands of specialists who ordinarily can perform these functions much more economically than can an individual business. While lending and collection are separable functions, they are also naturally combined. In my own case, hospitals for whom I presently provide billing services have asked if I might also arrange advances against accounts so as to reduce even further their payment delays. I must emphasize that the cash flow squeeze is particularly acute in the health care industry.

Despite the economic advantages to providers that factoring allows, several arguments have been raised to support an outright ban on assignments, and hence a ban on services that rely on the security provided only by that device. There are two principal statements of the policy analysis behind the 1972 amendments and, therefore, behind section 26:

(1) Senate Finance Committee Staff Report, "Medicare and Medicaid—Problems, Issues, and Alternatives," 91st Cong., 2d Sess. 130 (1970) (Exhibit A hereto); and

(2) Senate Finance Committee Report, "Social Security Amendments of 1972," to Accompany H.R. 1, 92d Cong., 2d Sess. 204–05 (1972) (Exhibit B hereto).

The documents reveal five principal arguments against allowing assignments of accounts:

(1) Assignments present an opportunity for greater fraud and abuse, by way of incorrect and inflated claims.

(2) Assignments create an additional cost to the provider which is indirectly passed on to the programs.

(3) Assignments create additional administrative problems for the government, principally in the area of recovery of overpayments.

(4) Providers can borrow against their Medicare and Medicaid receivables anyway without resort to outright assignment of claims.

(5) The proper solution to the provider's desire for prompt payment lies in streamlining processing of claims by the government and intermediaries.

These five arguments are rebutted hereafter in turn.

1. There Is No Increased Opportunity For Fraud Attributable Solely To The Allowance Of Assignments

The legislative history places primary emphasis upon past abuses as a rationale for abolishing assignments. It is argued that since Medicare and Medicaid frauds have involved both overbilling and assignments, therefore overbilling will be reduced if assignments are prohibited. Yet in this syllogism the premises do not support the conclusion. Although in a simplistic sense an assignee is one additional person in the chain of claims submission, no significant increase in attempted program fraud is likely to be created thereby because a sound auditing program will detect fraud by whomever it is committed. The audit process for detecting abuses by dishonest billers and punishing the offenders is essentially the same, whether it be providers or assignees who are billing and collecting for the services rendered. No greater level of auditing intensity will be required with assignments than without; in fact, it appears that fraudulent billings by assignees would be detected more easily than those by providers.

The prevention of fraud in Medicare and Medicaid billings is not essentially different from any other type of crime prevention—the potentially dishonest party has to be aware that he or she has a good chance of being caught, and that the penalty will be severe enough to make it unwise to commit the crime. This requires a sound auditing theory and design, plus credible communications to all involved about the effectiveness of the system and the penalties for violation. The Office of Central Fraud and Abuse Control, provided for under Section 2(b)(2)(A) of S. 3205, and the Inspector General for Health Administration therein created, should be charged with responsibiilty for establishing such audit procedures to the extent necessary to preclude most abuses.

I will make a few suggestions as to the necessary audit measures, dealing first with those related to hospitals and then with those related to physicians. I will also illustrate why these functions are totally unaffected by the party doing the billing, whether provider or assignee.

The audit of the properiety of the hospitals' billings should consist primarily of a visit to the hopsital and examination of medical records and physician authorizations for services rendered, including review of the "utilization review" function at any given hospital. This could be done for all billings if deemed necessary but, more practically, it would be limited to a percentage of cases selected by a reliable statistical sampling technique. Additionally, confirmations could be requested from program beneficiaries that they received the service billed; however, this may not be as satisfactory because many program beneficiaries are not aware of the charges for services received in a hospital. An additional technique would be to ascertain that a claim for a particular patient's hospital stay was not submitted twice. This should ordinarily be easily detected by the programs' fiscal intermediary by matching claims for a given patient to see that payments made for a specific stay or date of service were not duplicated. Moreover, advance approvals are now obtained from the programs for each stay.

There are at least two audit techniques for physicians available. The most productive technique would be to ask program beneficiaries, probably on a test basis, to confirm services received. Such a confirmation might list the amounts paid to and services provided by a certain doctor in a certain month, together with a request to the patient to please notify the Department of any discrepancies "so that your Medicare (Medicaid) account can be properly adjusted." This type of confirmation should uncover incidents of overbilling or billing for services not rendered. For example, if a patient had a finger x-rayed, but the program has been billed for a chest x-ray, the patient might reply something like "no chest x-ray done, my left index finger was x-rayed once," a reply which would lead to further investigation.

The second technique use for an audit of physicians would entail visits to their offices and inspection of their medical records, but this would probably not be as effective.

The important point is that the above procedures would not be any different for a provider of service who assigns accounts receivable than for one that does not assign.

Actually, a fraudulent assignee could probably be more easily detected than a fraudulent provider. Consider the possible methods that could be used by an assignee to defraud the programs: (1) the amount of the charges could be raised from those submitted by a provided; (2) the assignee could bill for services not rendered; or (3) the assignee could double bill for services rendered. In case (1), as soon as an auditor visited the provider's office and discovered that the provider's bill for services was greater than the records showed, the fraud would be immediately discovered. Or, in case (2), if a nonexistent hospital stay is billed, that fact would become immediately obvious. In all cases the provider has the greater opportunity to initiate fraud and the mechanism needed to detect fraud is the same.

No double audit will be involved because the above auditing techniques can be carried out solely at the offices of the provider, and with the proper audit system, there is absolutely no increase in opportunity for fraud due to the assignment of claims. A provider has a much greater ability to manipulate medical records than an assignee has to raise amounts supplied to him by the provider. While we do not have access to any details of the frauds referred to in the Staff Report and Committee Reports, we are convinced that the key problem in all of them was a defect in the basic auditing system rather than any problem arising from assignments. The corrective legislation needed for this problem relates to audit design, not the identity of the payee.

Program Costs Are Necessarily Decreased, Not Increased, If Assignments Are Used

The second reason for the denial of assignment, that the Medicare and Medi-Cal programs would pay additional costs because of the assignments, is patently false. If the provider determines that assignment is financially advantageous to him, after evaluating the costs of assignment and/or factoring against the costs of not doing so, it is obvious that the cost to the government programs will also be proportionately less, in terms of interest expense and billing and collection expense. In most cases experienced assignees are specialized and can do a more efficient job of billing than is possible by most service providers. The assignee's charge is counterbalanced by these efficiency improvements; furthermore, the agent's fee can only be lower if it is secured by an assignment than if the agent is taking more risk of nonpayment. Likewise, there must be interest expense savings to the provider in the case of factored accounts, or else the services will not be used.

The language in Section 26 infers that a problem is created by an agent (or assignee) charging in proportion to the amount billed. This manner of charge is common business practice. The fee arrangement does not change the conclusions relative to fraud or cost discussed above. Presumably, the provider will have concluded that for his operations (whether hospital or otherwise) the arrangement is financially advantageous.

I will illustrate the factors that go into this cost calculus by reference to the typical service which my organization provides. Our overall objective is to increase hospital cash flow. This is done by developing effective policies and procedures for a hospital's business office operation and its interface with other hospital departments. Specifically, Kenneth Associates assists hospitals in developing and implementing improved procedures for the preparation and submission of billing claims, principally (but not exclusively) Medicare and Medicaid (Medi-Cal) claims. Our own personnel sometimes perform the hospital's billing operations and may also perform follow-up services, such as revision of claims, contesting claims, and collection agency referrals. More frequently, our staff trains a hospital's personnel to perform these functions. Another variation in service involves specific oversight of billing operations. Our usual method of operation is to establish a target figure of average days revenue outstanding and then to reach the target by a combination of improvements in internal efficiency and improvements in approaches to government and third-party payors.

Our success has been outstanding. For example, since 1971, we have recovered twenty million dollars ($20,000,000) for San Francisco General Hospital, at a cost to the hospital not exceeding three hundred thousand dollars ($300,000).

Our customary fee arrangement for billing services is based upon a specified percentage of the billings and is conditional upon successful collection of the accounts. This formula is advantageous to the provider because it gives the agent an incentive to increase the accuracy and timeliness of claims submissions, which is after all the principal benefit which the agent provides. If these two incentives are taken away, as Section 26 would do in situations where the agent desired to take an assignment to secure his fee, the agent must be paid either at an hourly rate or on a piece-work basis, neither of which have any built-in incentives to the agent which would be attractive to a provider. The structure of the proposed exception operates on the premise that claims submission is a routine clerical process, while in truth the amount to be recovered from any given billing is very much in flux and the skill which the billing agent brings to this task, both in terms of accurate filing (to avoid subsequent resubmission) and of proper categorization (so as to maximize revenue), is what creates the value or benefit of his services in the eyes of the provider.

I will concede that the taking of an assignment is not necessary to an incentive fee arrangement as just described. To date we have conducted our business without assignments to secure our fee and we could continue to do so under the proposed Section 26. My points are that the fee with an assignment could only be lower because of a lower risk of nonpayment, and that there is no logic to the structure of the exception written into the bill.

A similar cost calculus is involved in the cases of pure factoring and/or lending on the security of accounts. While we do not presently provide such financing services, we have devised a plan to provide such, in order to assist hospitals in coping more effectively with the current payment delays, which average sixty days under Medicaid. Under the plan, we would arrange an immediate advance of money to hospitals on the security of an assignment of their Medicare and Medicaid accounts. Alternatively, we would arrange the outright purchase of such accounts at a discount, commonly known as "factoring." Using such services, a hospital could receive cash proceeds (less a specified discount) within a matter of days after patient services are performed, rather than months later when the claim is paid. Kenneth Associates is in a position to obtain the necessary financing for this plan through reputable banks at favorable rates because the value of a hospital's accounts receivable is enhanced by the hospital's utilization of our billing services.

It is evident that providers, especially hospitals, currently face a serious cash flow situation and that in many cases they are already engaged in unsecured short-term borrowings against their receivables, or borrowing by such means as delaying payments to suppliers. My proposed factoring plan would be a more economical substitute for such existing financing, rather than a new and unnecessary cost to providers and the programs.

In conclusion, the present cost to providers of delay in receiving payment from the government and intermediaries is very real and is already being passed on to patients and the programs in increased charges and decreased service *The issue to be decided is which cost is greater*. In my view, the decision on this issue should be left to each hospital and physician, to be made in light of each one's own immediate economic realities. The only conceivable situation where this type of arrangement would result in higher overall costs to Medicare would be where the agent or assignee were related to the provider of service; in such a case the existing regulations on "related organizations" (20 C.F.R. § 405.427) provide a means to limit the portion of such costs which will be reimbursed.

3. *Any Increase In Administrative Problems Will Be Minor*

Specific problems mentioned in the Committee Reports were those related to "determinations of reasonable charges and recovery of overpayments." The former matter is but one element of the fraud problem and the solution is the audit system discussed above. Since the claim must in all cases have attached to its documentation generated by the provider and be supported by the provider's internal records, the assignment adds nothing whatsoever to the problem of evaluating the claim, any more than it increases the likelihood of fraud.

Recovery of overpayments is not affected by whether the overpayments were made to a provider or to an assignee. Essentially the government's ability to recover overpayments will always depend upon its inherent control over the provider. The first recourse would be to hold back on those accounts already in the pipe line and due to the provider or assignee. In most cases the amount of this backlog would be far more than enough to cover any retroactive adjustment of payments already made. Assuming that payments are made on the average within thirty days of billing, the uncollected amount at any given time, when considered along with those services rendered but not yet billed to the programs, would approximate ten percent of the annual total volume. As a further control over the provider, the government has the threat of disqualifying the provider from participation in the program. For most hospitals, the Medicare and Medicaid programs constitute such a large percentage of their business that they could not operate without these programs: this threat would receive instant attention.

The important point here, once again, is that the government's remedies are the same whether overpayments were made to a provider or an assignee. The remedy of offset against the provider's billing in process will be effective even in the event that the provider terminates from the programs or the assignee terminates his participation in the assignment, so long as a certain notice period is required during which the government can hold up payments pending a final settlement of accounts. Finally, our information is that program overpayments have in fact become more rare in recent years.

The impact of the federal Assignment of Claims Act (31 U.S.C. § 203 and 41 U.S.C § 15, as amended) on administrative problems has generally gone unnoticed. Even if Congress allows assignments under Medicare, the general federal provisions will still govern the mechanics and will impose administrative safeguards on the practice of making assignments. For instance, an agent supplying biling services will still not be able to take a blanket assignment of all claims but will be limited to taking an assignment of each payment after the check has been issued. A bank or factor will not be able to take assignment of some claims but not others, and will not be able to reassign a claim to still another party.

Most of the administrative problems which have been postulated are not serious obstacles. Strangely enough, Section 26 allows assignment of payments to a certain type of collection agent without any provisions for meeting these alleged administrative problems, indicating that the Staff does not see these as serious matters. I, however, see that the administrative mechanics should be the principal focus of regulatory effort. In my suggested amendments and related comments I have outlined procedures which will make an assignment system workable.

4. *Alternative Security Devices Are Not As Effective*

One argument against the need for factoring is that providers can effectively borrow against their Medicare and Medicaid accounts receivable by means of devices which do not entail outright assignments. For instance, in the Committee Report, it is stated that even after the 1972 amendments, a provider may have a payment check in his name mailed to some other organization, such as to a bank, for deposit in a special account. Another possibility is that a provider may "list" his receivables as an asset for the purpose of persuading a bank to lend him working capital. Blue Cross Association, Provider Release Bulletin, No. 58–19.

Although the above devices do provide some potential for borrowing against receivables, they do not provide the nearly-perfect security which an assignment offers and hence they entail either lower loan proceeds or higher interest rates than would otherwise be the case. Speaking directly from my experience, I can say that the banks with which I have discussed my proposed factoring arrangement have stated that they would not advance the necessary funds to allow the operation unless a binding assignment can be obtained, while with an assignment they will advance the funds at a favorable interest rate because the value of the accounts is enhanced by the hospitals utilization of our regular billing services. Thus the assignment is the key hinge of the whole service, and the value of the supposed alternatives is, in fact, illusory.

These arguments do, however, point up a key fact in the debate about the wisdom of assignments, which is that all of the services herein discussed (processing and lending) and all of the potential abuses connected therewith will continue to exist even if assignments are prohibited. That is, submission of claims by an agent and lending against accounts receivable can and will be carried out without the use of an assignment as a security device. The difference that Section 26 will make is that more legitimate agents and banks will be deterred to varying extents, relative to those who will provide the services taking more risks for a greater return.

5. Streamlined Processing By The Government Is Not A Feasible Solution

The Staff's response to the genuine need for "immediate cash," admitted in its 1970 Report, is that "streamlining administration and processing" will make factoring unnecessary. Section 4(a) of S. 3205, adding subparagraph (39)(A) to Section 1902(a) of the Social Security Act, attempts to implement this solution by mandating that State Medicaid programs must provide procedures which assure that 95 percent of "clean claims" shall be paid within 30 days of receipt of the claim from the provider, and 99 percent within 90 days. If a State does not meet such targets, after notice of deficiency and up to six month's opportunity for correction, it may, under Section 4(c) (adding subsection 1903(n) to the Act), have its Federal matching funds for administrative costs reduced by 50% or terminated, while a State which substantially exceeds this and one target may have its Federal matching increased to 75 percent.

My experience with the Medicaid program in California (California Medical Assistance Program, or Medi-Cal) leads me to believe that this 30 day target for payment may be impractical and infeasible. On the average, claims are paid by Medi-Cal after about 60 days and this has been the average for several years. Medicare payments are generally made by SSA in less than four weeks, but Medi-Cal is much slower. Furthermore, California has had a requirement since 1965 that contracts between the Department of Health Care Services and fiscal intermediaries shall provide that payments will be made within 30 days from receipt of documentation. Cal. Welf. & Inst'ns Code § 14104.3 (1971), replacing § 14104(c)(6) (1965). This requirement has been ignored in practice and has never been consistently met in my experience. In fact, § 14104.3 was amended in 1972 (1972 Cal. Stats., ch. 1019, p. 1889, § 1) to provide that notice shall be given to the provider within 60 days if the bill is "held for peer review" beyond 30 days. Even this loophole in the statute has not been complied with, in my experience, although the theoretical penalty for noncompliance was termination of the contract with the carrier. Cal. Welf. & Inst'ns Code § 14106 (1965, repealed 1972).

While I cannot be certain that the proposed Sections 4(a) and 4(c) will be ineffective, I would suggest that there are serious problems arising from the nature of Medicaid claims evaluation which cannot simply be legislated out of existence. At the least, such a 30 day requirement even if it works is no substitute for a financing plan which provides cash to the provider within a matter of days.

SUMMARY

The policy arguments in favor of abolishing assignments are misdirected because they do not bear upon the incremental costs attributable solely to the taking of an assignment as a security device (which are minimal) and they ignore the benefits to providers which this device allows (which, based upon an assessment of the particular economic situation, may be great). I urge Congress not to adopt Section 26 of this bill.

EXISTING LAW SHOULD BE CLARIFIED

Even if Section 26 is not enacted, there remain serious uncertainties in existing law relating to the status of assignments of Medicare and Medicaid accounts.

We feel that Congress should, based upon a full review of the merits discussed above, clarify the law in these respects and expressly state that there is no general policy against legitimate assignments and factoring.

DHEW has taken the position that all assignments of claims under Medicare are prohibited, based upon the language of § 1814(a)(1) of the Social Security Act, 42 U.S.C. § 1395f(a)(1), and that commercial assignments of Medicaid payments are also barred. Our research indicates that the Department was fully in error when it first adopted its position and remains, despite amendments to the Act, partially in error.

1. Medicare Part A

The original Medicare law, enacted as Public Law 89–97 (79 Stat. 286) on July 30, 1965, created sections 1814(a) and 1835(a) of the Social Security Act (42 U.S.C. §§ 1395f(a), 1395n(a)), which provided that payment for covered services under Parts A and B "may be made only to providers of services" that have an agreement with DHEW under Section 1866 of the Act and only if certain procedural steps are followed. There was no similar language for the Medicaid program.

We respectfully submit that this language was not intended to bar assignments for the following reasons:

(a) This language, on its face, does not bar assignments. It merely limits providers who may participate in the program to those who have an agreement with DHEW and who follow certain procedural steps. It is amenable to the interpretation that payment to an agent or assignee of the provider satisfies its terms. The legislative history repeats the statutory language, but without the word "only", thus further negating the inference that the language was meant to bar assignments. There was no discussion of the problem of assignments at that time.

(b) The applicable DHEW regulation (20 C.F.R. § 405.150) recites that amounts payable under Medicare Part A are payable "only to a participating provider of services." This regulation is compatible with the above, if it is understood merely as defining certain providers who could claim payments and not as having anything to do with the subject of assignments.

(c) Subsequent legislative material indicates that DHEW did, in fact, honor assignments in the early years of the programs. Senate Report No. 92–1230 (1972) recites, at pages 204–05 (Exhibit B hereto):

"The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs. The Department of Health, Education, and Welfare makes such reassigned payments under medicare without specific legislative authority."

In addition, DHEW comments on Medicaid (Hearings of the Senate Subcommittee on Medicare and Medicaid, 91st Cong., 2d Sess., pt. 1, at 165, 189 (1970)) recite:

"Assuming that independent collection and bill discount agencies now operate legally, legislation will be required to prohibit States from making vendor payments to such agencies from Title XIX program funds."

The premise of this statement is that the orginal Medicare and Medicaid law did not prohibit assignments, even with the language about "only to providers."

(d) On October 15, 1969, HEW Secretary Finch submitted the "Health Cost Effectiveness Amendments of 1969." They were discussed in the House Ways and Means Committee Hearings on "Social Security and Welfare Proposals," 91st Cong., 1st Sess. at pages 133, 1058 and 2108. The amendments embodied many changes designed to improve efficiency of administration, but they did not include a ban on assignments. Thus, as of that date, the Administration did not view assignments as a problem.

(e) Section 236 of the 1972 amendments to the Social Security Act, discussed below, made no change in Medicare Part A.

Therefore, our analysis of the law shows that assignments of payments under Part A are *not* prohibited by law, despite the position taken by DHEW.

2. Medicare Part B and Medicaid

In 1972, Public Law 92–603 changed the law to add provisions to the Medicare Part B and Medicaid law to the effect that no payment can be made to "anyone other than" a provider. These changes are now found at 42 U.S.C. §§ 1395u(b)(5) and 1396(a)(32). They are followed by regulations at 20 C.F.R. § 405.1680 and 45 C.F.R. § 249.31, respectively, adopted in early 1974. Although the stated language does not differ linguistically from the original ("only to providers"), the accompanying legislative history clearly indicates that a partial ban on assignments, particularly in the context of factoring, was intended.

I have two key points to make about these 1972 amendments. First, they were not preceded by a thorough discussion in the public record of the merits of a ban on assignment. Second, the legislative intent was limited to a ban on fraudulent assignments.

The effort to prohibit assignments originated with a Staff Report of the Senate Finance Committee, entitled "Medicare and Medicaid: Problems, Issues and Alternatives," dated February 9, 1970. The key paragraphs of this Staff Report are set forth in Exhibit A attached hereto. No preceding House or Senate hearings dealt with this aspect of the Report; apparently the information upon which it is based was directed to the Staff informally. Clearly the Staff Report operates on the assumption that, as of that time, assignments were permitted. The principal points made by the Staff analysis are dealt with in the above analysis of Section 26 of S. 3205.

The Staff recommendations were incorporated as Section 234 of H.R. 17550 in January, 1970. The Senate Finance Committee held hearings on this bill under the title of "Social Security Amendments of 1970" (91st Cong., 2d Sess.) on June 17 and July 14, 15, 1970. The testimony was remarkably muted with respect to the issue of assignments. The American Public Health Association endorsed the ban (page 712), on the grounds that "it will guard against unethical—even immoral—practices." The Blue Cross Association omitted any comment on this change (page 777), as did the American Medical Association (page 1083). The Senate Finance Committee Report on the bill, S. Rpt. No. 91–1431, dated December 11, 1970, sets forth the text of Section 234 without comment.

H.R. 17550 did not pass in 1970, but was reintroduced virtually unchanged as H.R. 1 in the first session of the 92nd Congress. The ban on assignments was designated Section 236. This bill became Public Law 92–603, enacted on October 30, 1972. Hearings on the bill before the Senate Finance Committee, under the title of "Social Security Amendments of 1971," on July 27, 29 and August 2, 3, 1971, contained no discussion on the question of assignments.

The relevant committee reports on this bill are: House Ways and Means Committee Report No. 92–231, dated May 26, 1971; Senate Finance Committee Report No. 92–1230, dated September 26, 1972; and House Conference Report No. 92–1605, dated October 14, 1972. The key paragraphs from the Senate Report are set forth as Exhibit B attached hereto. The wording is nearly identical to that used in the House and Conference Reports, set forth in 1972 U.S. Code Congressional & Administrative News at pages 4989, 5090–91 and 5370, respectively, and the earlier House Report No. 91–1096 dated May 14, 1970. The concerns expressed are similar to those in the above Staff Report.

We cannot find any foundation for the Reports' comments, or even any discussion of the matter, in prior hearings In short, this important amendment was adopted without a public disclosure of the alleged abuses and without a full discussion of the pros and cons of factoring from the provider's point of view.

The critical sentence in the Committee Report, which is not reflected in the statutory language, states that the ban on assignments does not apply to payments "based on the reasonable cost of the services." Logically this could mean that the cost of the agent's or factor's services must be reasonable, but grammatically the terms "the services" in that paragraph can refer only to services of a provider. Thus, the Congressional intent as expressed in the Committee Reports is that only "incorrect and inflated claims" are not assignable. This is a peculiar proposition, because the remedy for fraud in any case is, immediately, to stop payment and, over the long term, to improve auditing, Yet this reading of the intent relates directly to the concern for fraud expressed in the preceding paragraph of the Report. Any administrative problems arising from the legitimate assignment of claims based upon reasonable costs of the provider were evidently not operative concerns in the 1972 amendments.

Once again, a thorough analysis of the law reveals that the position taken by DHEW—that all assignments are banned—is not supported by the legislative history. I ask that Congress now consider the issues raised on the merits. The following section contains my suggestions about the form of an optimal amendment.

PROPOSED AMENDMENTS SHOULD BE ADOPTED

Exhibit C attached hereto sets forth a revision of section 26 in the form which I believe best responds to the issues raised above The principal emphasis in drafting, once it is recognized that assignments do fulfill a need of providers, is to devise safeguards to maximize the public benefit of factoring.

As was stated above, the principal concern—fraud—is logically an unrelated problem, for which the solution is auditing integrity. There is little that legislaton can do to provide safeguards against certain abuses that are possible with or without assignments.

An assignment should be permitted pursuant to a court order, in which case any potential problems would be subject to public scrutiny. My amendments allow assignments to be made, in addition, to either the billing agent or a financing institution, but to no other parties, because the incremental benefits to providers are greatest in relation to these two kinds of services, and because allowing other miscellaneous assignees will increase the costs of administering an assignment system. An assignment will not be allowed betwen two related organizations, as defined in the regulations, so that the fee and interest arrangements will always be the result of arm's-length negotiation.

I considered including percentage limitations on discounts allowable for billing service fees and interest, in order to satisfy the public interest, but have concluded that the existing program limitations provide adequate protection against unreasonable costs and charges. The determination of disallowances of interest or collection expenses is best left to be handled on a case-by-case basis. Furthermore, setting a fixed maximum discount to cover all situations would be infeasible, in light of the differences, for instance, between the collectibility of in-patient and out-patient accounts.

The federal Assignment of Claims Act provides a satisfactory solution to problems relating to administrative simplicity of assignments. The standards of that general Act (differing as they do as applied to regular agents and financing institutions) are incorporated into my suggested Medicare amendments. These standards briefly provide that any regular assignment of a claim against the United States, or any power of attorney for receiving such a claim is void unless made after the allowance of the claim, the ascertainment of the amount due (which could in the case of these programs be an estimated amount), and the issuing of a check for payment, and unless executed before two witnesses and acknowledged before a public officer (e.g., a notary public). However, assignments of claims to a "bank, trust company, or other financing institution" need not comply with the above procedures, if the contract under which the claim arises allows such assignment and provides for payments aggregating at least $1,000, and if (unless the contract excepts these) the assignment covers all unpaid amounts payable under the contract and is not made to more than one party or made subject to further assignment (but it may be made to an agent of two or more parties participating in the financing). In the event of such a bank assignment, written notice and a copy of the assignment shall be filed with the contracting agency and the surety and disbursing officer, if any.

Because Medicare provider contracts are open-ended in duration, it is impractical to assign "all amounts" payable until the end of participation in the programs. In order to conform with these federal provisions, the contracts will have to be revised to permit assignment of less than all amounts payable. My suggestion is contained in the amended text: the contract will permit only assignments that cover all amounts payable either until a fixed date or until a fixed number of days (at least 90) after notice of termination is given to the payor.

In the case of Medicaid accounts, the law of the State in which the assignment is made should provide comparable protections.

CONCLUSION

This presentation of the pros and cons of assignments and factoring has shown that most of the incremental costs of an assignment system are insubstantial when compared with the potential benefits of such a system during the current cash flow crisis faced by providers, and that in any case such an economic decision should be made on a case-by-case basis at the level of the individual facility. The only true incremental cost to the government is the administrative expense of keeping track of assignments. Legislation should attempt to minimize this factor without abolishing a practice which fulfills such an urgent need of providers. Therefore, I urge that the approach embodied in Section 26 should be abandoned and that amendments along the lines I have suggested should be adopted.

Exhibit A

Excerpt from Senate Finance Committee Staff Report, "Medicare and Medicaid—Problems, Issues and Alternatives," 91st Cong., 2d Sess. 130 (1970):

END PAYMENTS TO COLLECTION AGENCIES

Prohibit making of vendor payments (under medicare as well as medicaid) to independent collection and bill discount agencies—to anyone other than the person or institution rendering the service.

The staff's attention has been called to the increasing usage by physicians, pharmacists, and some hospitals of independent collection agencies to whom they assign their medicaid and medicare billings.

Apart from the opportunity for fraud and abuse which sanction of such agencies affords—criminal indictments have been handed down in New York in one such case—the costs of using those agencies are obviously indirectly passed on to the program.

Such agencies are employed because they offer to relieve physicians, pharmacists, dentists and others of cumbersome paperwork and provide immediate cash for medicaid due bills which the practitioners might otherwise have to wait months to collect.

The solution, however, lies in stream-lining administration and processing—including making timely payment—rather than use of costly and problem-creating outside collection and discount organizations.

Exhibit B

Excerpt from Senate Finance Committee Report, "Social Security Amendments of 1972," to Accompany H.R. 1, 92d Cong., 2d Sess. 204–05 (1972).

PROHIBITION AGAINST REASSIGNMENT OF CLAIMS TO BENEFITS (SEC. 236 OF THE BILL)

Under present law, payment for services furnished by a physician or other person under the supplementary medical insurance program is made: (1) to the beneficiary on the basis of an itemized bill, or (2) to the physician or other person who provided the services on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service. Present law also provides that payment for such services under the medicaid program is made to the physician or other person providing the services. The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs. The Department of Health, Education and Welfare makes such reassigned payments under medicare without specific legislative authority.

Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name. Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in the medicare program, one involving over a million dollars.

The committee concurs with a provision in the House bill which seeks to overcome these difficulties by prohibiting payment under these programs to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. Also, direct payment could be allowed to a foundation, association, plan, or contractor which provides and administers health care through an organized health care deliver system. An example of this type of organization would be a prepaid groups practice or other system recognized by the State title XIX agency. It is not the intent of the committee that this provision apply to payments to providers of services that are based on the reasonable cost of the services.

This provision would not preclude a physician or other person who provided the services and accepted an assignment from having the payment mailed to anyone or any organization he wishes, but the payment would be to him in his name.

The provision would in no way interfere with the fiscal relationships between physician and hospitals in the case of hospital-based pathologists and radiologists, for example.

This provision as it applies to medicare would be effective with respect to bills submitted after the enactment date. For medicaid the provision would be effective January 1, 1973, or earlier if the State plan so provides.

Exhibit C

ASSIGNMENT OF FEES BY HOSPITALS, PHYSICIANS AND OTHERS

Sec. 26. (a) Section 1815 of the Social Security Act is amended by adding at the end thereof the following new subsection: "(c) Any payment for a service, which under the provisions of this section and the preceding section may be made directly to the hospital or other facility furnishing such service, may be made to a person claiming such payment under an assignment, including a power of attorney, if (but only if) : the assignment is established by or pursuant to the order of a court of competent jurisdiction from such hospital or other faciltiy furnishing such service; or the assignment is in favor of an agent of the hospital or other facility furnishing such service (who is not related to such provider), is pursuant to an agency agreement under which compensation is paid to the agent for his services for or in connection with the billing and/or collection of any such payment, and complies in all respects with the Assignment of Claims Act (31 U.S.C. § 203 and 41 U.S.C. § 15, as amended) ; or the assignment is in favor of a bank, trust company, or other financing institution (within the meaning of said Act), and complies in all respects with the exception provided therein, but the assignment may provide for a portion of the discount to be attributable to services of an agent who provides billing and/or collection services. For these purposes only, the provider's contract shall be deemed to provide for payments aggregating $1,000 or more and shall be deemed to permit an assignment of all amounts payable under the contract until a fixed date at least 90 days after the date of assignment or until a fixed number of days (at least 90) after notice to the payor of intention to terminate the assignment."

(b) Section 1842 (b)(5) of such Act is amended by adding at the end thereof the following new sentence: "Any payment for a service, which under the provisions of the preceding sentence may be made directly to the physician or other person furnishing such service, may be made to a person claiming such payment under an assignment, including a power of attorney, if (but only if) : the assignment is established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service; or the assignment is in favor of an agent of the physician or other person furnishing such service (who is not related to such provider), is pursuant to an agency agreement under which compensation is paid to the agent for his services for or in connection with the billing and/or collection of any such payment, and complies in all respects with the Assignment of Claims Act (31 U.S.C. § 203 and 41 U.S.C. § 15, as amended) ; or the assignment is in favor of a bank, trust company, or other financing institution (within the meaning of the Assignment of Claims Act, 31 U.S.C. § 203 and 41 U.S.C. § 15, as amended), and complies in all respects with the exception provided therein, but the assignment may provide for a portion of the discount to be attributable to services of an agent who provides billing and/or collection services. For these purposes only, the provider's contract shall be deemed to provide for payments aggregating $1,000 or more and shall be deemed to permit an assignment of all amounts payable under the contract until a fixed date at least 90 days after the date of assignment or until a fixed number of days (at least 90) after notice to the payor of intention to terminate the assignment."

(c) Section 1902(a) (32 of such Act is amended—

(1) by inserting "(A)" immediately after "provide that",

(2) by redesignating clauses (A) and (B) as clauses (i) and (ii), respectively, and

(3) by adding immediately before the semicolon at the end thereof the following, ", and (B) any payment for a service, which under the provisions of subparagraph (A) may be made directly to the physician or other person furnishing such service, may be made to a person claiming such payment under an

assignment, including a power of attorney, if (but only if): the assignment is established by or pursuant to the order of a court of competent jurisdiction from such physician or other person furnishing such service; *or* the assignment is in favor of an agent of the physician or other person furnishing such service (who is not related to such provider), is pursuant to an agency agreement under which compensation is paid to the agent for his services for or in connection with the billing and/or collection of any such payment, and complies in all respects with applicable State law relating to the assignment of claims against the State; *or* the assignment is in favor of a bank, trust company, or other financing institution (within the meaning of the Assignment of Claims Act, 31 U.S.C. § 203 and 41 U.S.C. § 15, as amended) and complies in all respects with applicable State law relating to the assignment of claims against the State, but the assignment may provide for a portion of the discount to be attributable to services of an agent who provides billing and/or collection services.".

(d) The amendments made by this section shall take effect on the first day of the first calendar month which begins not less than sixty days after the date of enactment.

Mr. ROSTENKOWSKI. Thank you, Mr. Kenneth.

Mr. Duncan?

Mr. DUNCAN. No questions. Thank you very much.

Mr. ROSTENKOWSKI. Thank you, sir. This will conclude the testimony of the committee's sitting this afternoon. We will adjourn until 8:30 tomorrow morning and the committee stands adjourned.

[Whereupon at 11:45 a.m. the committee was recessed to reconvene at 8:30 a.m., on Thursday, September 16, 1976.]

[The following was submitted for the record:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., September 8, 1976.

Hon. AL ULLMAN,
Chairman, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in further response to your inquiry regarding reimbursement rates between Blue Cross and Blue Shield of Greater New York and Group Health Incorporated. The study which you suggested of this complex situation has taken a good deal of time, and I regret that because of that, this response has been delayed.

Our New York Regional Office has now completed its reasonable charge study of the New York City area, and I enclose a copy of the results. All of the accumulated data and the description of the computations are somewhat formidable, but basically the study shows that the different reimbursement levels of the carriers are due primarily to diverse physician charging patterns between the two service areas. This is evidenced particularly in Charts A and C of the study. In other words, under the Medicare statute and regulations, the program's payments for physicians' services result from the actual charging practices of physicians in a given area, and the study indicates that the different levels of reimbursement in New York City do not result from differing patterns or procedures of the two carriers but rather from the differing charge practices of the physicians in their respective areas.

You will be interested to know that the Social Security Administration plans to continue monitoring this area and is currently negotiating with the New York City College Graduate School to conduct an independent analysis on the reimbursement levels in the New York City area. We expect to complete plans for this analysis within the next month.

Similar information is being sent to other Members of Congress who also inquired about this matter.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

Enclosure.

STAFF ANALYSIS: DIFFERENCES IN PREVAILING CHARGES LEVELS BETWEEN BLUE CROSS BLUE SHIELD OF GREATER NEW YORK AND GROUP HEALTH INCORPORATED

I. GENERAL INTRODUCTION

When payment on Medicare supplementary medical insurance claims is made on a "reasonable charge" basis, the "reasonable charge" for a service is set at *either* the actual charge made, *or* the physician or supplier's individual "customary charge" for the service *or* the "prevailing charge" in the physician or supplier's locality, *whichever is lowest*. Thus, prevailing charges repesent the upper limits of Medicare reasonable charge reimbursement within a locality and specialty. A Medicare carrier's customary and prevailing charge screens are developed before the start of each fiscal year from the charges submitted during the previous calendar year.

This "reasonable charge update" is a series of computer routines using the carrier's paid claims history as input. Necessary charge data is extracted from the history, formatted and sorted by physician/supplier number and procedure code number. Steps are taken to exclude "bad data," for example, the results of miscodings by claims examiners. The median of a physician or supplier's charges for each different procedure is then selected as his or her *customary charge* for that service.

Prevailing charges are then computed by sorting individual physician/supplier customary charges by locality, by specialty as applicable, and by procedure. The customary charges are then arrayed in ascending order and weighted by the total number of times the procedures was performed by the physician/supplier during the base year. The 75th percentile of the weighted customary charges is selected as the prevailing charge for the concerned locality, specialty and procedure.

Each of the prevailing charges thus developed is then compared to the prevailing charges that were in effect during Fiscal Year 1973 (those prevailings that went into effect in July 1972 based on calendar year 1971 charges). Only a certain percentage increase over the FY 1973 prevailings may be allowed, based on a national Economic Index. The allowable percentage increase was 17.9% for Fiscal Year 1976, the period used in this study.

Bureau of Health Insurance (BHI) guidelines covering the development of reasonable charge screens allow carriers latitude in the procedure used to recognize possible different charging patterns between the various medical specialties. Blue Cross-Blue Shield of Greater New York (BSGNY) develops separate prevailing charges under two specialty categories. The first is composed of general practitioners, family practice specialists, osteopaths of various specialties, podiatrists and, for certain procedures, chiropractors. The second category groups all other board eligible specialists. For want of better terminology, we will call the two categories "non-specialists" and "specialists", respectively.

Besides having a "non-specialist" category similar to BSGNY's, Group Health Incorporated (GHI) develops separate prevailing charge screens for 28 physician specialties.

GHI regards the whole of Queens County as a single locality for reasonable charge purposes, while BSGNY divides its sixteen county service area into five reasonable charge localities. In this study, we have concerned ourselves with the three BSGNY localities that include all areas contiguous to Queens: Localities A, B, and E. "Locality A" is Manhattan, "Locality E" is Nassau County; "Locality B" is composed of Brooklyn, the Bronx, Staten Island, and Westchester County. Various geographical, social and medical factors would lead one to expect that Queens would compare most closely to "Locality B". We have, therefore, made this the prime comparison in the study.

Medicare program guidelines require carriers to use, when available, comparable charge data other than from the Medicare program in developing reasonable charge screens. Approximately 26% of the data used by GHI comes from the administration of a "usual and customary charge" private business insurance plan. BSGNY only recently began recording charge data that can be merged with the Medicare data; therefore, their Fiscal Year 1976 screens were based solely on Medicare data. BSGNY plans to include charges obtained in administering CHAMPUS, FEHBP, and one private business contract with the Fiscal Year 1978 update.

II. STUDY METHOD AND CONCLUSIONS

The purpose of this study was to investigate in some depth a number of recent complaints that GHI's rates of reimbursement were much lower than SGNY's.

The study concentrated on prevailing charges, and the data supporting them. The 39 high volume procedures in Part B Intermediary Letter #74–19 were used as a sample, in addition to five procedures mentioned in the inquiry from the Queens County Medical Society. The following steps were taken in the study:

A. Prevailing charges with and without the Economic Index adjustment were compared on a one-to-one basis between GHI and the three BSGNY localities mentioned above. The comparisons for specialists were made based on a weighted average of GHI's specialty prevailings. To determine the effect of the differences in prevailing charge levels, payments were projected using numbers of services in Queens.

B. Computation of prevailing charges by both carriers was rechecked, duplicating Bureau of Health Insurance annual review procedure.

C. GHI redeveloped prevailing charges using only Medicare charge data to determine whether their private business charges were adversely affecting prevailing charge levels.

D. Recent statistics on amounts or percentages of reasonable charge reductions were compared for the two carriers.

The conclusions of the study were:

1. There are significant differences in reimbursement levels between GHI and BSGNY. Projections made in this study suggest that 12% and 18% more would be paid, under BSGNY's Locality B prevailings, for specialists and non-specialists respectively, than under the GHI prevailings. The differences found comparing GHI and BSGNY's Localities A and E were more pronounced.

2. Both GHI and BSGNY follow Medicare program guidelines in computing prevailing charges.

3. The differences in prevailing charge levels between GHI and BSGNY's Locality B are not the result of an unequal effect of the recently instituted economic index limitation on increases in prevailing charges. In addition, the differences are not the result of including private business data in the data base used by GHI in developing their reasonable charge screens.

4. The two carriers are very close in the percentage of charges reduced on reasonable charge grounds. Although the only statistics available are for the carriers as a whole, we believe the comparison is applicable between GHI and BSGNY's Locality B.

Both carriers were found to be applying the reasonable charge guidelines correctly, and the differences in prevailings were not found to be related to differences in methodology. Rather, the study indicates that the differences in prevailing charge levels are based on differences in physician charging patterns between Quens and BSGNY's Locality B (as well as Localities A and E). In this regard, specific reference is made to Charts A and C which compare the prevailing charges unadjusted by the "Economic Index" factor. As the prevailing charge is based directly on the submitted charges and the utilization of the 75th percentile, it is clear that the pattern of submitted charges is different. However, more detailed study and analysis will be required to determine the precise, actual experience and differences in charging patterns.

III. DETAILED DISCUSSION

A. Comparison of prevailing charge levels

Prevailing charges for the 44 sample procedures are shown on Charts A through D.

We compared prevailings for specialists and non-specialists both with and without Economic Index adjustments. Only the adjusted prevailings are used in pricing claims, but the unadjusted prevailings more accurately reflect the level of physicians charges.

Using the statistics for numbers of services in Queens during calendar year 1974 and GHI's adjusted prevailings for the sample procedures, we projected a total payment of $24,312,141.50 for the sample. GHI's total benefit payments for the six month period July through December 1975 were approximately $37,030,000. Thus, the value of the sample represents approximately one-third of GHI total annual benefit payments. Since benefit payments also include payments for the services of hospital-based physicians, ambulance services, durable medical equipment, etc., the sample represents a considerably larger percentage of the payment for physician services reimbursed on a reasonable charge basis.

(*i*) *Nonspecialist comparison*

The comparison of prevailing charges (with the E I adjustment) for nonspecialists showed that GHI's prevailings compare most favorably with those of BSGNY's "Locality B" but that, even in this case, where comparison was possible, 41% of the sample procedure were lower for GHI.

However, it is interesting to note that comparisons of unadjusted prevailing charges for nonspecialists show that the GHI data-based prevailings were lower than that of "LocalityB" in 50% of the sample cases where comparison was possible. This suggests that the difference is not the result of the Economic Index adjustment.

The full comparison for non-specialists was as follows:

COMPARISON OF NONSPECIALIST PREVAILINGS

BSGNY locality	Without EI			With EI		
	B	E	A	B	E	A
Number of comparable prevailings	28	23	24	27	24	24
GHI prevailing:						
Lower	14	15	13	11	15	14
Equal	6		4	7	2	4
Higher	8	8	7	9	7	6
Percent where GHI lower	50	65	54	41	54	58

This gross comparison of charge levels seems to show that the allegations of generally lower reimbursement levels at GHI have a solid basis in fact. It also seems to indicate that this difference is based on lower data-based 75th percentiles, rather than on inequality in the effects of Economic Index adjustments.

In addition to gross comparison of sample prevailings, we attempted to gauge the relative effect of the difference in prevailing charge levels between GHI and BSGNY's Locality B. Using data on the frequency in Queens of billings during calendar year 1974 for the sample procedures, we projected payment at the prevailing charges and compared the results.

This analysis showed that $6,404,437.50 would have been paid at GHI's prevailing rates. Payment under the BSGNY Locality B prevailings would have resulted in an 18% increase to $7,558,137.60.

(*ii*) *Comparison for specialists*

As mentioned above, BSGNY computes one set of prevailing charges for specialists while GHI computes 28 separate sets. To compare the two carriers, we computed a weighted average of GHI's specialist prevailings for the sample procedures. This Average Specialist Prevailing (ASP) was computed as follows:

$$ASP=\frac{(p_i f_i)+\ldots\ldots+(p_n f_n)}{f_i+\ldots\ldots\ldots\ldots+f_n}$$

where p_i=a prevailing charge for some specialty, f_i=GHI's total frequency for the base period (calendar 1974) for the procedure and specialty for which p_i is the prevailing.

Average Specialist Prevailings were computed in this way using values both with and without Economic Index adjustments and used as the GHI prevailings in Charts C and D.

Again, GHI's rates compare least favorably with those for Manhattan, but rather than being closest to those for "Locality B", it seems that they compare most favorably with those for Nassau County (Locality E). In any case, simple comparison of the prevailing charges for specialists shows a significantly wider gap in reimbursement levels than the same comparison for non-specialists.

A full comparison is as follows:

COMPARISON OF SPECIALIST PREVAILINGS

BSGNY locality	Without EI			With EI		
	B	E	A	B	E	A
Number of comparable prevailings	44	43	43	44	43	43
GHI prevailing:						
Lower	29	24	38	33	26	39
Equal	1	1	1		2	
Higher	14	18	4	11	15	4
Percent where GHI lower	66	56	88	75	60	91

Again, in order to gauge the dollar value of the difference, a projection of payments was made using the numbers of services for Queens physicians in calendar year 1974.

Payments at the GHI prevailings would have been $17,903,704. Payment at BSGNY's Nassau County rates would have been $20,297,203, a 13% increase, while payment at the "Locality B" rates would have been $20,020,329, a 12% increase.

Interestingly enough, this analysis shows GHI again closest to Locality B and also shows less differences in payment levels than for non-specialists.

B. Computation of prevailing charges

Given the interest in this matter by persons and organizations unfamiliar with reasonable charge computations and with the normal review procedures used for reasonable charge updates, we thought it best to formally address the possibility that the differences in reimbursement levels might be based on differences in the basic method used to generate prevailing charges.

Actually, the basic methodology to be used was spelled out in a policy release by BHI prior to the July 1971 reasonable charge update (Part B Intermediary Letter #71–9, April 1971), and has remained the same since. The procedure itself is very simple, and a standard point of any review agenda for a reasonable charge update is to check the computation of "75th and 50th percentiles". Each time an update is performed, carrier personnel and BHI personnel independently review the new screens. The Part B Model System programs are used by 21 carriers, including GHI. EDSF services 11 Part B carriers, among them BSGNY. No problem in the basic prevailing charge computation procedure has been found.

The point, of course, is that we have very good reason to hold that both carriers compute prevailing correctly. Nonetheless, as part of the study we revalidated prevailing charge computation procedures at both carriers. No problems were found.

C. The effect of GHI—Private business data

In order to test the hypothesis that GHI's lower prevailings were the effect of the inclusion by GHI of charges obtained through certain lines of their private business, GHI, at our request, redeveloped their Fiscal Year 1976 prevailings using only Medicare data.

We checked the results of this for the larger specialties and found no reason to believe that the GHI private business charges are lowering the Queens prevailings. In fact, any trend that exists seems to run in the opposite direction.

The following chart shows the results of this:

Specialty	Number of comparable prevailings	Medicare only prevailing compared to actual prevailings		
		A. number higher	B. number lower	C. number same
Nonspecialist	71	15	30	26
General surgeon	55	5	16	34
Internal medicine	94	11	25	58
Anesthesiology	46	14	15	17
Radiology	48	7	17	24
Orthopedic surgery	45	6	20	19

If the GHI private business data were weighting the data base down, one would expect the results of excluding it to raise prevailing charge levels. As the chart shows, this did not happen.

D. Statistics on Reasonable Charge Reductions

GHI and BSGNY are very close in statistics they report to SSA on reasonable charge reductions. We have arrayed below their most recent figures on amounts and percentages of charges reduced on reasonable charge grounds for SSA–1490 claims. By limiting them to SSA–1490 claims, these statistics include payment for ambulance services, durable medical equipment, etc., as well as physician services, but exclude cost-based payments to hospitals and group practice prepayment plans for the services of their physicians. These figures are only available for the two carriers as a whole; separate figures are not maintained for BSGNY's different localities.

	Total covered charges on SSA-1490 claims	Total reduction on reasonable charge grounds	Percent of charges reduced
January to March 1975:			
BSGNY	$110,339,192	$24,285,760	22
GHI	13,071,794	2,501,893	19
April to June 1975:			
BSGNY	116,014,687	27,494,245	23
GHI	13,010,629	1,683,472	20
July to Spetember 1975:			
BSGNY	129,645,055	29,251,266	22
GHI	12,492,585	2,807,278	22
October to December 1975:			
BSGNY	119,519,806	27,809,220	23
GHI	12,469,562	1,939,547	23
January to March 1976:			
BSGNY	148,664,424	36,484,234	24
GHI	8,852,881	2,126,545	24

These figures clearly show the two carriers almost identical in the overall percentages of charges disallowed on reasonable charge grounds. Where there are differences in this respect, it is BSGNY which shows the more severe percentage reduction.

CHART A

PREVAILING CHARGES, NONSPECIALISTS WITHOUT ECONOMIC INDEX ADJUSTMENT

CRVS code	Description	GHI[1]	BSGNY, locality B	BSGNY, locality E	BSGNY locality A
9002	Initial office visit	$25.00	$20.00	$20.00	$25.00
9004	Routine followup OV	11.00	12.00	12.00	15.00
9022	Initial hospital visit	25.00	30.00	35.00	50.00
9024	Routine followup HV	15.00	15.00	15.40	20.00
0130	Incision and removal of foreign body	25.00	27.00	18.00	28.30
0140	Dramage of hematoma	24.00	25.00	15.00	15.00
0171	Biopsy—skin	51.00	45.00	[1]	
0245	Removal of malignant lesion (1)	100.00	224.00	[1]	200.00
0246	Removal of malignant lesion (2)	[1]	[1]	[1]	[1]
0470	Radical mastectomy (4)[2]	850.00	[1]	[1]	[1]
0868	Reduction of fracture—femur	[1]	1,150.00	1,275.00	[1]
1767	Amputation—lower leg	[1]	[1]	[1]	[1]
2111	Bronchoscopy	[1]	[1]	[1]	[1]
2445	Blood transfusion—indirect	[1]	31.25	[1]	[1]
3178	Colectomy, partial	[1]	1,060.00	1,200.00	[1]
3261	Appendectomy (4)[2]	400.00	[1]	[1]	[1]
3311	Sigmoidoscopy	30.00	30.00	25.00	35.00
3380	Hemorrhoidectomy	360.00	[1]	[1]	[1]
3515	Cholecystectomy (3)[2]	800.00	1,400.00	[1]	[1]
3571	Exploratory laparotomy	[1]	[1]	[1]	[1]
3631	Repair hernia—inguinal	332.00	510.00	600.00	
3931	Cystoscopy	[1]	30.00	[1]	125.00
4031	Dilation of urethra—male	15.00	25.00	[1]	
4316	Prostatectomy (suprapubic)	[1]	[1]	[1]	[1]
4321	TUR	[1]	[1]	[1]	[1]
4631	Hysterectomy—vaginal(3)[2]	850.00	910.00	[1]	[1]
5613	Extraction of lens	[1]	[1]	[1]	[1]
7100	Chest X-Ray	20.00	20.00	25.00	20.00
7215	X-ray, spine, lumbosacral	45.00	30.00	40.00	40.00
7356	X-ray, stomach	100.00	75.00	105.00	75.00
7360	X-ray, colon, barium enema	90.00	70.00	60.00	75.00
7301	X-ray, hip, complete study	35.00	22.50	30.00	25.00
7603	Cobalt radiotherapy treatment	[1]	30.00	[1]	15.00
8652	Cholesterol	5.50	6.00	8.00	8.00
8628	CBC	7.00	8.00	8.00	8.00
8622	Hemoglobin	3.00	3.00	4.00	5.00
8681	Hematocrit	3.75	5.00	4.00	5.00
8708	Prothrombin time	7.00	5.00	8.00	10.00
8720	Sedimentation rate	5.00	5.00	6.00	5.00
8722	Blood sugar	.50.0	6.00	7.00	6.00
8911	Pap smear	15.00	10.00	10.00	10.00
8936	Urinanalysis	3.00	3.00	4.00	4.00
9107	EKG	20.00	25.00	25.00	20.00
9330	EEG (3)[2]	50.00	[1]	[1]	[1]

---

[1] Insufficient data to generate a prevailing.

[2] Number of services is shown when less than 5.

CHART B

CRVS code	Description	GHI [1]	BSGNY, locality B	BSGNY, locality E	BSGNY, locality A
9002	Initial office visit	$23.60	$17.70	$17.70	$23.60
9004	Routine followup OV	9.40	11.80	11.80	14.20
9022	Initial hospital visit	25.00	23.60	29.50	23.60
9024	Routine followup HV	14.20	15.00	15.40	17.70
0130	Incision and removal of foreign body	23.60	17.70	18.00	23.60
0140	Drainage of hematoma	23.60	23.60	15.00	15.00
0171	Biopsy—skin	29.50	29.50	(1)	23.60
0245	Removal of malignant lesion (1)	100.00	117.90	(1)	117.90
0246	Removal of malignant lesion (2)	(1)	(1)	(1)	(1)
0470	Radical mastectomy (4)[2]	766.40	(1)	(1)	(1)
0868	Reduction of fracture—femur	(1)	736.90	1,179.00	(1)
1767	Amputation—lower leg	(1)	(1)	(1)	(1)
2111	Bronchoscopy	(1)	(1)	(1)	(1)
2445	Blood transfusion—indirect	(1)	29.50	(1)	(1)
3178	Colectomy, partial	(1)	943.20	825.30	(1)
3261	Appendectomy (4)[2]	400.00	(1)	(1)	(1)
3311	Sigmoidoscopy	29.50	29.50	25.00	29.50
3380	Hemorrhoidectomy	235.80	(1)	(1)	(1)
3515	Cholecystectomy (3)[2]	589.50	560.00	(1)	(1)
3571	Exploratory laparotomy	(1)	(1)	(1)	(1)
3631	Repair hernia—Inguinal	332.00	477.50	412.70	(1)
3931	Cystoscopy	(1)	29.50	(1)	(1)
4031	Dilation of urethra—male	15.00	(1)	(1)	(1)
4316	Prostatectomy (suprapubic)	(1)	(1)	(1)	(1)
4321	TUR	(1)	(1)	(1)	(1)
4631	Hysterectomy—vaginal (3)[2]	586.00	825.30	(1)	(1)
5613	Extraction of lens	(1)	(1)	(1)	(1)
7100	Chest X-ray	17.70	17.70	23.60	20.00
7215	X-ray, spine, lumbosacral	35.40	29.50	29.50	29.50
7356	X-ray, stomach	64.90	75.00	76.60	75.00
7360	X-ray, colon, barium enema	70.70	70.00	53.10	75.00
7301	X-ray, hip, complete study	23.60	22.50	23.60	25.00
7603	Cobalt radiotherapy treatment	(1)	23.60	23.60	15.00
8652	Cholesterol	5.50	6.00	8.00	8.00
8628	CBC	7.00	8.00	8.00	8.00
8622	Hemoglobin	3.00	3.00	4.00	5.00
8681	Hematocrit	3.75	5.00	4.00	5.00
8708	Prothrombin time	7.00	5.00	8.00	10.00
8720	Sedimentation rate	5.00	5.00	6.00	5.00
8722	Blood sugar	5.00	6.00	7.00	6.00
8911	Pap smear	15.00	10.00	10.00	10.00
8936	Urinanalysis	3.00	3.00	4.00	4.00
9107	EKG	20.00	2.500	24.80	18.60
9330	EEG (3)[2]	47.20	(1)	(1)	(1)

---

[1] Insufficient data to generate a prevailing.
[2] Number of services is shown when less than 5.

CHART C

9002	Initial office visit	$33.89	$30.00	$30.00	$40.00
9004	Routine followup OV	15.83	16.00	17.00	25.00
9022	Initial hospital visit	44.22	50.00	45.00	50.00
9024	Routine followup HV	19.84	20.00	20.00	25.00
0130	Incision and removal of foreign body	26.36	58.30	(1)	85.00
0140	Drainage of hematoma	20.13	50.00	116.70	86.70
0171	Biopsy—skin	33.81	35.00	35.00	50.00
0245	Removal of malignant lesion (1)	153.07	150.00	175.00	200.00
0246	Removal of malignant lesion (2)	214.38	250.00	300.00	300.00
0470	Radical mastectomy	902.08	1,000.00	1,000.00	1,500.00
0868	Reduction of fracture—femur	1,309.98	1,500.00	1,500.00	1,550.00
1767	Amputation—lower leg	671.74	795.00	600.00	1,000.00
2111	Bronchoscopy	246.15	250.00	250.00	300.00
2445	Blood transfusion—indirect	50.00	47.50	15.00	50.00
3178	Colectomy, partial	1,121.88	1,360.00	1,250.00	1,560.00
3261	Appendectomy	500.00	500.00	650.00	(1)
3311	Sigmoidoscopy	32.08	35.00	30.00	40.00
3380	Hemorrhoidectomy	463.51	515.00	450.00	525.00
3515	Cholecystectomy	750.12	800.00	750.00	1,000.00
3571	Exploratory laparotomy	723.14	750.00	650.00	900.00

CHART C—Continued

CRVS code	Description	GHI[1]	BSGNY, locality B	BSGNY, locality E	BSGNY, locality A
3631	Repair hernia—inguinal	504.30	500.00	500.00	750.00
3931	Cystoscopy	53.80	100.00	50.00	100.00
4031	Dilation of urethra—male	19.91	20.00	25.00	30.00
4316	Prostatectomy (suprapubic)	850.00	1,000.00	943.00	1,325.00
4321	TUR	825.00	990.00	870.00	1,250.00
4631	Hysterectomy—vaginal	700.00	1,000.00	800.00	1,000.00
5613	Extraction of lens	800.00	850.00	800.00	1,000.00
7100	Chest X-ray	23.57	23.00	20.00	25.00
7215	X-ray, spine, lumbosacral	46.06	45.00	45.00	50.00
7356	X-ray, stomach	76.88	80.00	80.00	100.00
7360	X-ray, colon, barium enema	76.47	75.00	70.00	90.00
7301	X-ray, hip, complete study	31.39	25.00	25.00	25.00
7603	Cobalt radiotherapy treatment	34.05	25.00	25.00	45.00
8652	Cholesterol	5.32	6.00	7.00	7.00
8628	CBC	8.91	8.00	10.00	10.00
8622	Hemoglobin	3.08	4.00	3.00	5.00
8681	Hematocrit	5.48	3.00	4.00	5.00
8708	Prothrombin time	4.99	6.00	6.00	10.00
8720	Sedimentation rate	5.05	5.00	5.00	5.00
8722	Blood sugar	5.54	5.00	7.00	6.00
8911	Pap smear	14.56	10.00	7.00	10.00
8936	Urinanalysis	3.40	4.00	4.00	5.00
9107	EKG	24.96	25.00	25.00	25.00
9330	EEG	48.22	50.00	60.00	75.00

CHART D

9002	Initial office visit	$29.28	$29.50	$29.50	$40.00
9004	Routine followup OV	13.35	16.00	17.00	23.60
9022	Initial hospital visit	40.34	35.40	35.40	41.30
9024	Routine followup HV	18.08	17.70	20.00	25.00
0130	Incision and removal of foreign body	21.24	41.30	(1)	41.30
0140	Drainage of hematoma	16.72	50.00	47.20	59.00
0171	Biopsy—skin	33.40	35.00	35.00	41.30
0245	Removal of malignant lesion (1)	149.78	150.00	175.00	194.50
0246	Removal of malignant lesion (2)	188.21	250.00	294.75	294.75
0470	Radical mastectomy	880,61	1,000.00	884.25	1,179.00
0868	Reduction of fracture—femur	943.20	1,179.00	1,179.00	1,532.70
1767	Amputation—lower leg	589.50	648.50	589.50	825.30
2111	Bronchoscopy	233.05	200.40	235.80	235.80
2445	Blood Transfusion—indirect	17.70	47.20	15.00	50.00
3178	Colectomy, partial	880.15	1,179.00	1,120.10	1,473.75
3261	Appendectomy	433.90	500.00	518.80	(1)
3311	Sigmoidoscopy	31.20	29.50	29.50	40.00
3380	Hemorrhoidectomy	431.80	442.10	383.20	525.00
3515	Cholecystectomy	706.70	800.00	707.40	1,000.00
3571	Exploratory laparotomy	573.26	707.40	589.50	884.25
3631	Repair hernia—inguinal	469.57	471.60	442.10	648.50
3931	Cystoscopy	52.43	188.40	50.00	94.30
4031	Dilation of urethra—male	17.61	20.00	17.70	23.60
4316	Prostatectomy (suprapubic)	850.00	960.90	854.80	1,179.00
4321	TUR	825.00	884.25	766.40	972.70
4631	Hysterectomy—vaginal	648.50	884.25	707.40	1,000.00
5613	Extraction of lens	800.00	850.00	800.00	1,000.00
7100	Chest X-ray	21.64	23.00	20.00	23.60
7215	X-ray, spine, lumbosacral	44.10	45.00	45.00	50.00
7356	X-ray, stomach	75.96	80.00	76.60	88.40
7360	X-ray, colon, barium enema	74.33	75.00	70.00	88.40
7301	X-ray, hip, complete study	30.19	25.00	25.00	25.00
7603	Cobalt radiotherapy treatment	31.70	23.60	25.00	41.30
8652	Cholesterol	5.32	6.00	7.00	7.00
8628	CBC	8.91	8.00	10.00	10.00
8622	Hemoglobin	3.08	4.00	3.00	5.00
8681	Hematocrit	5.48	3.00	4.00	5.00
8708	Prothrombin time	4.99	6.00	6.00	10.00
8720	Sedimentation rate	5.05	5.00	5.00	5.00
8722	Blood sugar	5.54	5.00	7.00	6.00
8911	Pap smear	14.56	10.00	7.00	10.00
8936	Urinanalysis	3.40	4.00	4.00	5.00
9107	EKG	23.50	24.50	25.00	25.00
9330	EEG	44.61	49.10	60.00	75.00

---

[1] Insufficient data to generate a prevailing.

Department of Health, Education, and Welfare,
Social Security Administration,
Baltimore, Md., March 31, 1976.

Hon. Al Ullman,
Chairman, Committee on Ways and Means, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in further response to your inquiry on behalf of Alexander M. De la Garza, M.D., President-Elect, Medical Society of the County of Queens, 112–25 Queens Boulevard, Forest Hills, New York. He had written to you about fee profiles in the New York City boroughs. I regret the long delay in my reply.

Variances between reasonable charge screens established by adjacent carriers are the result of differences in the charging patterns of physicians, specialty practice, and economic characteristics in different areas. Also, individual carriers within the guidelines established by law, regulations, manual instructions, and other controls are permitted a certain amount of administrative freedom and discretion in the way they perform their functions. For example, Blue Shield of Greater New York includes every medical specialty in one prevailing charge screen while Group Health Inc. (GHI), the Medicare carrier serving Queens County in New York City, has a prevailing charge screen for every specialty. Neither of these practices is inconsistent with our current instructions, but we will of course consider appropriate action if our study indicates that this is a significant factor in causing disparities between the two areas.

Customary charges of physicians are influenced by and tend to reflect the general income levels in the areas they serve. A special factor in this situation is that the highest priced specialists in the New York City area are found in Manhattan which is serviced by Blue Shield of Greater New York, and which has within it many teaching hospitals and such renowned institutions as the Columbia-Presbyterian Medical Center, and the Sloan-Kettering Institute for Cancer Research.

Medicare's reasonable charge screens which are constructed from the actual charges of physicians recognize the difference in patterns of fees, *which have been established by the physicians themselves,* and of course, the Medicare program makes no judgment as to the value of the services of physicians in one area as compared to those in another part of a State.

Our New York Regional Office has for some months been conducting a detailed analysis of the Group Health Inc.-Queens County situation and expects to complete their study by about May 1 of this year. They have had difficulty in obtaining some of the data because of a strike at GHI. We will supply you with information from this study as soon as it becomes available.

Similar information is being sent to Representative Lester L. Wolff who also inquired on behalf of Dr. De la Garza.

Sincerely yours,

Thomas M. Tierney,
Director, Bureau of Health Insurance.

Congress of the United States,
House of Representatives,
Washington, D.C., December 9, 1975.

Hon. Al Ullman,
Chairman, Committee on Ways and Means, Longworth Building.

Dear Mr. Chairman: I am enclosing for your consideration correspondence I recently received from the Medical Society of the County of Queens with regard to the disparity between Medicare Profiles in Queens, where GHI is the carrier, and in surrounding counties, where Blue Shield is the carrier.

I would greatly appreciate your comments on the problem discussed in the enclosed, and thank you for your attention to this matter.

Sincerely,

Lester L. Wolff,
Member of Congress.

Medical Society of the County of Queens, Inc.,
Forest Hills, N.Y.

Dear Congressman: This is an introductory letter to the enclosed Surgical Exhibits regarding *Medicare Part B Prevailing Charges in New York City.*

As it was presented to Queens Congressmen at a meeting on Sunday, November 2nd, at the Queens County Medical Society, there exists a great disparity in the Medicare Profiles between the boroughs where Blue Shield is the carrier and the borough where GHI is the carrier. Unfortunately, Queens is the borough which belongs to the latter classification.

On page 1 of the enclosed attachment, a comparison is made of prevailing fees in the borough of Manhattan—Bronx, Brooklyn, and Staten Island—and Queens. You will immediately note that the Queens patient's reimbursement is 30% to 60% lower than that of other boroughs in New York City.

Page 2 of the Exhibit is a photocopy sent to me recently of my own personnel profile by Group Health Incorporated.

Page 3 is a sample of GHI profiles. This is to be compared with page 4, which is a sample of the same procedures, but with Blue Shield Reimbursement Rates.

I think you will immediately find it obvious that the Queens Patients are being sadly and discriminatorily neglected. If it is in fact true that the Health Systems Agencies state that all patients in a given geographic area should receive equal reimbursement and therefore treatment, according to the usual and customary fee of that area, then I would like to point out that, even in New York County, there exists great disparity as to doctors' overheads and customary fees in high and low cost areas. Yet no adjustment is being made to resolve this problem.

Queens doctors, on the other hand, certainly have at least as high overhead expenses as their fellow physicians in the Bronx, Brooklyn, Staten Island, and higher than in certain areas of Manhattan. Yet, their patients receive far lower reimbursement under this program.

As a result of this, more and more physicians in Queens find themselves unable to accept assignments, and their elderly patients are placed in great economic difficulties. This is not fair to the patient and should not exist under the intent of the present Medicare Law.

The Physicians of the Queens County Medical Society respectfully request that you, our Congressmen, act upon this gross injustice as soon as possible, and remedy this situation.

Thank you sincerely,

Alexander M. De la Garza, M.D.,
President-Elect,
Medical Society of the county of Queens.

		Comparative profiles between—		
		Manhattan	Brooklyn, Bronx, and Staten Island	Queens
130	Incision and removal foreign body	35	50	23.60
140	Drainage of hematoma	75	70	17.70
245	Removal malignant skin lesion	175	150	88.40
3515	Cholecystectomy	1,000	770	600.00
3178	Colectomy—Large bowel resection	1,550	1,250	[1] 1,000.00
3571	Exploratory Laparatomy	870	750	600.00

[1] 900 customary.
[2] 500 customary.

Disparity of Fees Between GHI and Blue Shield

(By Max Eil, M.D.)

Where we were, where we went and where we are:

It became apparent in 1968/69 that prevailing fees for medical services in Queens were, in general, lower when compared with similar services in all contiguous counties, and, in particular categories from 33% to 100% lower. Because of these remarkable differences, the Queens Society of Internal Medicine held a series of meetings with the fiscal agent from Medicare, GHI from 1969 to '71 in an effort to achieve parity in our prevailing fee profiles with our neighbor counties. Frustrated and denied in our efforts under the guise of secrecy regarding prevailing fee schedules, we came to the undeniable conclusion in early '70 that GHI was ripping off thousands of our patients, who were not receiving their equitable fair share of return for similar services performed in all surrounding counties; therefore, in the spring of 1970, Queens County Medical Society unanimously approved a resolution to change our fiscal agent and so informed HEW. So what happened? You guessed it. Nothing. Not even a courtesy reply from HEW to my knowledge. However, we continued to push hard for our demands for parity. Finally, in 1971, we achieved a modicum of success in specific areas, but never quite equal to our neighbors. Underlying most of our frustrations was the secrecy regarding prevailing profiles, thus making it impossible to present profiles from either fiscal agent for comparison. Time after time, we were denied access to these schedules. Not until late 1973 was the secrecy ban removed by a court challenge. With this lid removed, it became apparent to all what we had said over and over again:

1. Why are we different?
2. Why are we in Queens being treated as step-children?
3. Why are we an anomaly?

It was still no easy task to obtain these schedules from either UMS or GHI.

Profiles of 1974/75 revealed an approach to parity, but major differences remained in fee allowances, coding and identifying services, in particular, medical services. On so many occasions I requested a uniform system of coding to be adopted by both carriers. This has not been achieved to date; for example, we, in Internal Medicine, identify as the hallmark of an Internist the comprehensive history and physical examination. This service was not identified as such from 1966 to 1973, but rather as an intial office visit and was reimbursed as such. Therefore, Brooklyn, where this service was identified, received $30.00 for this service and Queens, where it was not, received $15.00. Therefore, if a patient in Queens went to an internist in Queens, his maximal return was $12.00, but if he went to one in Brooklyn, he received $24.00. How many thousands of dollars were denied to Queens' patients merely because GHI did not identify this service? In fairness to the carrier, I must say this, $15.00 was raised to $25.00 in the 1970/71 profile. Our small modicum of success for Queens patients I alluded to earlier. Through 1973, the carrier kept saying it was identified, but this was not so. It was put into the 1972/73 profile, but, in fact, was reimbursed as an initial office visit.

I will not say too much about the new 1975/76 profiles. One of my colleagues will attempt to speak to this complex and incomprehensible subject. We are now back to 1970/71 plus 18%. How frustrating, how ridiculous, how cruel a blow to patients in Queens after we came ½ way round up the road.

Finally, what should be done:

1. Get rid of the roll-back brought about by HEW fiat. I'm sure Congress never intended this to happen. And, until you accomplish this, ask the carrier to pay 1974/75 fees for services through 6/30/75, so that these patients will not be penalized for submitting earlier bills after July 1st.

STATEMENT OF ÆTNA LIFE & CASUALTY, ROBERT E. STEWART, ASSISTANT VICE PRESIDENT, MEDICARE ADMINISTRATION

MEDICARE PHYSICIAN REIMBURSEMENT SYSTEM

I am Robert E. Stewart, Assistant Vice President, Medicare Administration, Ætna Life & Casualty. My company serves as Medicare Part A intermediary for approximately 715 institutional providers of health care located in 32 states and is Part B carrier in the states of Alaska, Arizona, Hawaii, Nevada, Oklahoma and Oregon.

In testimony before the Subcommittee on Wednesday, September 15, Mr. Lawrence D. Morderosian of Portland, Oregon expressed his displeasure with several aspects of the Medicare program and its administration. In criticizing the ever increasing disparity between the fees charged by physicians and the fees that are recognized under Medicare as allowable for benefit determination, he seemingly laid the blame for this situation on private insurance companies serving as Part B carriers. Since my company in the Part B carrier for his home state of Oregon, Ætna was specifically mentioned in his criticism.

In making payment of Medicare benefits for physician services, my company is following the legislated provisions of the program.

On page 2 of his written statement, Mr. Morderosian expresses shock at Ætna's determination of a "fair and reasonable" charge for the services of a physician. The "determination" which Ætna makes is rigidly dictated by factors specified by Congress and does not represent whims of our employees. Specifically, the maximum fee we can consider for benefit determination is the fee which represents the 75th percentile of fees charged by all physicians of like specialty in a geographic area for a given procedure or service. In determining such maximum or prevailing fee, Congress has further stipulated that it be based, *not on the current fees of physicians*, but on fees charged during a prior twelve-month period that, on the average, is 12 months old when the Medicare fiscal-year commences and is 24 months old when it ends. Because of this long, varying time lag, the 75th percentile limit and other governmental restrictions affecting the amount of a physician's fee that may be allowable under Medicare, national statistics published by the Bureau of Health Insurance for the quarter January-March 1976 reveal that Part B carriers had to disallow an average of 19% of the charges for covered services submitted before calculating Medicare benefits payable. Applying these national statistics to a single hypothetical physician's fee reveals the following:

Physician fee submitted	$500
19% disallowed (aforementioned national statistics)	—95
Amount on which benefit can be calculated	405
Medicare calendar year deductible (payable by beneficiary)	—60
	345
20% coinsurance (payable by beneficiary)	—69
80% payment by Medicare	276

In this example, built to illustrate recent national statistics, the Medicare Part B carrier would pay 55.2% of the submitted charge—not 80% as most beneficiaries believe to be their entitlement. Even if the annual deductible had already been met by prior expenses, the benefit payment would be only 64.8% ($324) of the physician's fee, rather than the expected 80%.

With this kind of disparity, it is not surprising that beneficiaries and physicians are confused and disenchanted with Medicare payments as they exist today. In making this type payment—correct according to existing legislation—Part B carriers are being unfairly and publicly criticized for something over which they have no control.

The Subcommittee has received considerable testimony on the problems stemming from the increasing disparity between Medicare payments and physicians' charges. However, contrary to Mr. Morderosian's inference, Ætna Life & Casualty and the other Part B carriers are not responsible for this disparity.

Thank you for receiving this statement.

AMERICAN ACADEMY OF FAMILY PHYSICIANS,
KENTUCKY CHAPTER,
Louisville, Ky., June 25, 1976.

Hon. JOHN B. BRECKINRIDGE,
Cannon House Office Building,
Washington, D.C.

MY DEAR BRECKINRIDGE: The enclosed resolutions were adopted by the Kentucky Academy of Family Physicians' Congress of Delegates on May 19, 1976, and are being forwarded to you for action.

Sincerely yours,

PAUL J. SIDES, M.D., *President.*

Enclosures.

RESOLUTION NO. 5

Introduced by: Floyd County Medical Society.
Title: Medicaid-Medicare.

Whereas, the Medicaid and Medicare Program in Kentucky have, since their inception, been fraught with problems for the physicians, and

Whereas, physician profiles are not frequently updated to reflect normal changes, and

Whereas, rural physicians, with similar training and providing similar services, usually receive less in fee than their urban counterparts, and

Whereas, the KMA Board of Trustees have now, by their action of supporting a single KPRO organization for Kentucky, are acknowledging "Standards of Care" throughout Kentucky, and

Whereas, the recruitment and retention of physicians in rural areas is a priority for Kentucky, and

Whereas, KMA dues and assessments are similar for both rural and urban physicians: Now, therefore, be it.

Resolved. That the Kentucky Academy of Family Physicians' Congress of Delegates direct the KAFP Board of Directors to hold the necessary meetings, to contact the appropriate organizations, and to work for reimbursement of physicians at their usual and customary fees for services billed to the Medicare/Medicaid Programs without regard to geographic location.

Resolution No. 5 was adopted on May 19, 1976, by the KAFP Congress of Delegates.

RESOLUTION NO. 2

Introduced by: KAFP Executive Committee.

Title: Dual Fee For Same Service.

Whereas, the KAFP has been opposed to a dual fee concept for the same service, and

Whereas, we have repeatedly gone on record as being in favor of usual, customary and reasonable reimbursement, and

Whereas, this type reimbursement would only divide our membership; therefore, be it

Resolved, That the KAFP go on record as being opposed to any dual fee program in concept or in practice.

Resolution No. 2 was adopted as presented with no changes on May 19, 1976, by the KAFP Congress of Delegates.

GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER,
Washington, D.C., August 13, 1976.

Hon. CHARLES A. VANIK,
Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. VANIK: I hope you will forgive the delay in my response to your letter dated July 12, 1976. Unfortunately, your letter arrived while I was on vacation and since I have just returned, I am trying to catch up on my correspondence.

Your letter requested that I further clarify the reimbursement formula developed by the American Academy of Physician's Assistants and Mr. Constantine. Basically, it is as follows: Each practice which takes care of medicare patients would determine what percent of the entire practice this accounts for (an example might be 25% of an entire patient population).

The next percentage which must be determined is a percent of the PA's yearly salary which can be attributed to care rendered to medicare patients (say 10% of 15,000/year or $1500.00). You would then multiply 25% by 1500.00, giving you a dollar figure. You then must determine a percentage figure for M.D. supervision of a PA's activity spent supervising the PA while he is taking care of medicare patients. In addition, a percentage must be added for office practice overhead costs. These percentages are then added and multiplied by the previously arrived at dollar amount which then gives you a final dollar figure. This figure cannot exceed twice the annual salary of the PA.. These dollars can be paid to a practice in 12-month intervals. The figures could be adjusted to account for seasonal patient influx and reassessed bi-annually to adjust for inflation or other economic pressures.

This equation can be considered non-inflationary because it can only be applied to M.D.'s who already care for medicare patients. In addition, this would render care at a lesser cost than if the M.D. were reimbursed at his usual and customary fee.

If I have failed to clarify this, I would be more than happy to meet with you or your staff to further discuss this reimbursement formula.

I will also obtain a copy of the National P.A. Study done in 1975, which arrived at the conclusions articulated during my testimony. I will send this to you under separate cover.

Again, I trust you will excuse the delay in my response and if I may be of further assistance, please contact me.

Sincerely yours,

JARRETT M. WISE, R.P.A.,
Director, Physician's Assistant Program.

STATEMENT OF THE AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

(By Robert G. Ojemann, M.D., Lester A. Mount, M.D., Louis A. Finney, M.D., Russel H. Patterson, M.D., Donald H. Stewart, Jr., M.D., and Charles A. Fager, M.D.)

The following statement on physician reimbursement under Medicare is submitted in behalf of the American Association of Neurological Surgeons with a membership of 1,862 and the Congress of Neurological Surgeons with a membership of 1,675.

In prior testimony to this subcommittee the American Association of Neurological Surgeons and the Congress of Neurological Surgeons emphasized that health care is a variable product and that the levels of care and attention demanded by different individuals show great variance and the levels of service required for the same illness by different individuals may show no correlation.

The Congress must always understand that the deliverance of health care is an art and not a pure science. Further, the art of health care delivery is a constantly changing skill. Although standards of care and model criteria sets have been devised, all reimbursement formulas for government supported health care programs must preserve mechanisms to allow for an individual approach in the treatment of all patients.

It is appropriate at this time to again bring to the attention of the Congress that major decisions in terms of both therapy and expense are cerebral decisions analytically determined by the provider. These cerebral decisions defy rational pricing as items of service. The current discussion of "unnecessary surgery" is worthy of mention at this time. The judgment not to operate, or not to perform unnecessary diagnostic studies or not to continue unnecessary hospitalization is a legitimate decision worthy of reimbursement. Physicians, to whom a life is entrusted during the storm of an illness, should, as the captain of a ship, be reimbursed for their services. Both physician and ship captain must avoid the perils of dangerous short cuts and unnecessary delay. The reimbursement must be for a job well done and not for individual acts of service. Thus, reimbursement formulas must strengthen and not erode the professional discipline and actions of the physician community. Therefore, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons recommend at this time that Congress continue provider reimbursement for government programs on the basis of usual, customary and reasonable fees.

At this time the Congress should take into consideration the fact that provider reimbursement represents only about twenty percent of the total Medicare annual expenditure and perhaps as little as twelve percent of the total Medicaid expenditure. Forty percent or more of all provider income is used to pay practice overhead. The net provider income which, after taxes, averages only eight cents of each Medicare dollar and four cents of each Medicaid dollar is shared by over 300,000 physicians.

Further, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons understand that the federal government has a finite limit of monies available to pay for medical services. We stress that these monies must be expended wisely. The division of these monies should be carefully considered by Congress. The most important decision for the future success of government health care programs is the determination of an optimum system for provider reimbursement.

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons at this time concur that the goal of the Medicare-Medicaid program should be the assurance of access to quality care for those without the financial means to obtain such care. Other issues, such as the improvement of the health of the citizenry, the assurance of services for consituents who may have problems of a social or personal nature not really requiring medical care, or the federal domination of the practice of medicine in the United States, should be considered in other legislation at another time.

A statement of the testimony of Mr. Michael Bromberg, Director of the National Offices of the Federation of American Hospitals, is worthy of repetition and is paraphrased by substituting the word provider for the word institution. "Congress must realize that Medicare has not paid its fair share of '*provider*' charges for Medicare and Medicaid beneficiaries, resulting in increased charges to non-government patients. Medicare must first acknowledge its obligation to pay a fair rate for services rendered".

In response to the invitation for commentary on specific issues, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons reply as follows:

ISSUE NO. 1

Undoubtedly fewer physicians are accepting the present Medicare reimbursement system for many reasons. Current regulations favor those physicians who had established a profile of higher charges when the system was implemented and penalize those physicians who did not increase their fees prior to implementation of the program. The program also penalizes the physician who is not continually revising his fee schedule upward in response to the inflationary increase in the expense of office space, labor, utilities, transportation, and in our specialty, malpractice insurance. Congress should realize that few physicians will be able to accept assignment until the Medicare reasonable charge approximates the private sector charge. Members of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons also feel that the Medicare intermediaries have become impersonal, arbitrary, and at times even capricious in handling claims. The standards for computing reimbursement vary between the intermediaries. Comments have been heard that the goal of intermediaries is to delay reimbursement and to reduce the reimbursement formulas. We have been advised that the New York state intermediary has reimbursed some neurological surgeons for only three days of each seven days of hospital care if an operation is not performed. Further, appeals mechanisms for small claims against the intermediaries are unduly burdensome and inconvenient for the provider. Resolution of these and other problems will be necessary prior to wider acceptance of assignment by physicians.

ISSUE NO. 2

Historically, the medical profession has exhibited humanitarian qualities by exercising discretion in the determination of fees. Further, the Congress should realize that all physicians are professional men, and that for reasons of propriety, sympathy, and understanding, may, even to this day, submit only token bills to certain patients and families. Such a practice penalizes the physician as a downward revision of his total profile is the result. This should not be allowed to happen and might be corrected by legislation eliminating the lowest ten percent of any physician's charges from computation of his profile or by allowing the physician to code a certain bill as being unusually low in sympathetic understanding of the family or patient circumstances, and thus having the specific charge excluded from computation of his profile. The right of a physician to choose which claims on which he will accept assignment must be preserved to ensure continued professionalism of the physician population. Arbitrary legislation which would require a physician to accept assignment would place the physician in the role of an indentured servant.

ISSUE NO. 3

Certainly, the federal government must realize that the expense of a medical practice in a metropolis such as Boston or New York City is greater than in rural areas. The same criteria apply to a neuro-surgical practice. The cost of office space, labor, transportation, and the time devoted to transportation are greater in certain urban areas. Therefore, the practitioner in the urban area charges commensurate with his practice expenses. These geographic variations cannot be cured by legislation. Unwise legislation in this area is liable to aggravate the problem.

ISSUE NO. 4

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons are of the opinion that neurological surgery may be practiced in any setting where adequate ancillary facilities have been provided.

Several multipurpose clinics in small communities but with large drawing areas provide excellent neurosurgical coverage to the citizens of those areas. Most standard metropolitan statistical areas now have neurosurgical coverage. We concur with recent studies that physician placement is largely a societal and not a financial decision. The only certain way to ensure larger numbers of rural practitioners would be to assist rural youth in their efforts for acceptance by a medical school in the same manner as recent efforts have assisted minority youths and the youthful female gain admission to medical schools.

ISSUE NO. 5

This is a philosophical and potentially explosive issue. Although specialist physicians have devoted from two to five or more years at subsistance wages to obtain their skills, there is no universal demand that their annual or career earnings should be higher than those of generalists. Physicians have become specialists so that they might render better quality care to their patients. This better quality care should be of greater financial value than care of less quality. Resultingly, specialized items of care should be reimbursed at a higher rate for sequences of service. The American Association of Neurological Surgeons and the Congress of Neurological Surgeons have empathy with those generalists who feel that in many instances the care they render is equal to if not superior to the care that might be rendered by specialists. Therefore, the solution to this problem is that specialized care must be considered analogous to intensive care and must be so rewarded by all provider reimbursement mechanisms.

ISSUE NO. 6

Recent action by the Federal Trade Commission and Department of Justice accusing physicians of fixing fees and similar conspiracies precludes physician commentary on this matter. However, the allegations must be resolved by the federal government and courts as soon as possible. The concept of some general level of reimbursement per item of care does exist and is generally recognized by all sectors of the health care industry as well as by the carriers and the government intermediaries. Perhaps the answer to this problem is to allow medical associations to legally discipline physicians who might charge unconscionable fees for their services.

ISSUE NO. 7

Although Relative Value Scales have received significant physician acceptance their legal status has also been clouded by recent Federal Trade Commission and Department of Justice action. Individual members have commented that Relative Value Scales prepared for state agencies have been distorted by arbitrary bureaucratic revision of the conversion factor. Thus, acceptance of a Relative Value Scale system would be acceptable only in a system which would preclude bureaucratic control of the conversion factors and which also would allow periodic negotiation or arbitration of both the designators and conversion factors by representatives of the involved provider disciplines, the carriers or intermediaries, and the involved government agencies.

ISSUE NO. 8

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons have no suggestions concerning experimental programs which might be alternatives or improvements to the current program.

ISSUE NO. 9

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons concur in the desirability for simplification of reporting by providers. It is well recognized that the cost of handling individual claims is now exorbitant and that the filing of multiple claims, especially for office care, on a single form would be of great savings. The American Association of Neurological Surgeons and the Congress of Neurological Surgeons have adopted a National Neurosurgical Procedural Terminology, which will be a part of the American Medical Association Current Procedural Terminology 4. However, federal intermediaries in many states have refused to accept claims filed under this coding system.

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons have previously proposed Specialty Advisory Panels on Data to authenticate the information which would be received under certain programs. Such a system would provide appropriate controls and preclude any need for a Health Care Financing Administration or an Office of Fraud and Abuse. In this manner bureaucratic costs could be reduced and the practice profiles of each provider reviewed by a panel of his peers.

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons have already testified in favor of broadening the Supplementary Security Income program with early determination of Medicare disability and associated earlier health care benefits for spinal cord injury, coma following head injury, disabling birth injuries, incapacitating strokes, and recurrent and potentially terminal malignancy.

We also endorse the concept that all state Medicaid plans reimburse physicians at the Medicare reasonable charge rate. We agree with the testimony of the AFL–CIO to this subcommittee that "the standard should be 100 percent of Medicare reasonable charges, otherwise there will be two standards of care—one for the poor and another for the Medicare population." Further, the Congress should outlaw by legislation capricious time limits for reimbursement under Medicaid. These programs penalize the professional concept of rendering a bill upon completion of services.

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons totally oppose section 20 of S. 3205.

Finally, Congress should understand that many physicians maintain the professional concept of donating services. Many of the members of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons give large volumes of service to those citizens in dire need who do not have private resources, who have never purchased health insurance, and who are not and never will be beneficiaries of any government plan. Unfortunately many physicians are now reluctant to care for these patients. Those physicians who do care for these patients are penalized not only in time, but in hospital and office paper work and in increased liability risk. If Congress really wanted to help those unselfish physicians who still serve those who never will be able to reimburse their physicians, Congress would find a way to convert all of those uncollectable bills into some form of tax credits or tax rebates. Such an action may be of much more value to society than any injudicious tampering with the current Medicare reimbursement formula for providers.

In summary, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons suggest that Congress take the following action in the matter of physician reimbursement under Medicare and Medicaid:

1. Maintain reimbursement on the basis of usual, customary, and reasonable fees.
2. Revise the reimbursement schedule so that it is not out of balance with the private sector.
3. Simplify appeals mechanisms so that beneficiaries or physicians may easily bring a grievance for prompt and judicious resolution.
4. Delete the lowest ten percent of any providers charges in computing his profile or allow certain low charges to be excluded from determination of fee profiles.
5. Maintain the right of physicians to choose those claims he or she might accept on an assignment basis.
6. Accept the current disparity in reimbursement schedules based on the expense of practice due to geographic location.
7. Ensure adequate rural health care coverage by enrichment programs to assist rural youth gain admission to medical schools.
8. Acknowledge that specialist medical care is analogous to intensive care and is accordingly reimbursed at a higher level per sequence of care.
9. Use their good office to assist in resolving the legal dilemma over fee schedules and relative value scales and possibly provide a legal mechanism for medical associations disciplining physicians who charge unconscionable fees.
10. Never consider adopting a fixed fee schedule or relative value scale without allowing for periodic renegotiation of the fees, designators, and conversion factors between the providers and intermediaries.
11. Order the intermediaries to adopt the American Medical Association Current Procedural Terminology 4.
12. Simplify the filing of multiple small claims of a repetitious nature by using a single claim report for multiple similar claims.

13. Create a Specialty Advisory Panel on Data for each specialty to validate all data concerning that specialty and negate any need for a Health Care Financing Administration or an Office of Fraud and Abuse.

14. Broaden the Social Security Administration Supplemental Income program to provide associated earlier health benefits for individuals truly dependent because of illness or injury.

15. Legislate that Medicaid reimbursement be 100 percent of Medicare reasonable charges.

16. Legislate a reasonable time of not less than six months for the filing of claims under Medicaid programs, and

17. Create a program of tax credits or tax rebates to reward those providers who care for the large number of patients who cannot pay their medical expenses and who are not beneficiaries of any government reimbursement program.

Thank you.

STATEMENT OF THE AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

The AFL–CIO believes that inefficiences and discontinuities in the nation's health care system are the fundamental cause of the problems in the Medicare program. The substantial increases in cost of Medicare are attributable not to deficiencies in program administration but to basic flaws in the health care system together with reimbursement methods proscribed in the law that tend to provide the wrong incentives.

The AFL–CIO condemns the abuse of the Medicare program in which some few doctors and others have indulged. Strong efforts to curb abuse and fraud are clearly in order but fraud and abuse are not significant causes of the escalating cost of health care. Conflict of interest transactions, the way physicians practice medicine and how they are paid, all have a greater impact on costs and are the principle cause of escalating costs.

For example, conflict of interest situations have increased significantly in recent years. Physicans invest in proprietary hospitals to which they admit their own patients. They invest in medical laboratories to which they send their specimens. They invest in nursing homes and refer their patients to them. Some even buy generic drugs, repackage them under a private brand name, raise costs substantially and then prescribe the brand name drug for their patients.

The Employee Retirement Income Security Act (ERISA), the new pension reform law, prohibits trustees of health, welfare and pension plans from engaging in conflict of interest transactions. Doctors should be similarly prohibited from engaging in such activity. Doctors would still be free to invest in hospitals, nursing homes and in medical laboratories, but should be prohibited from investing in facilities to which they refer or which provide services for their own patients.

Another major contributing factor in increasing health costs is the fact that 85 percent of physicians are solo practitioners. The best way to ensure better quality of care and greater economy is to use existing manpower more effectively through wider resort to group practice and reduce the need for hospitalization by better coordination of the whole package of available medical services. In short, reduce the waste of manpower and equipment of solo practice and emphasize preventive care.

While Medicare is an excellent program and has contributed enormously to the protection against the costs of health care so vital to the well being of our aged citizens, it has done nothing to overcome these problems inherent in the health care system. The cost reimbursement prescribed in law impartially rewards quality and subsidizes inefficiency. The law's reasonable charge reimbursement for doctors requires payment on the basis of whatever doctors in an area customarily charge. And every additional service, so long as it cannot be disallowed as clearly unnecessary, merits another charge and another Medicare payment. It is wrong to assume that the administrators of Medicare should somehow be able to overcome problems inherent in the law itself.

For example, under present law physician fees are defined as those which do not exceed the 75th percentile of actual charges in a given area. After that, allowable charges may be increased in the aggregate only to the extent justified by indexes reflecting changes in costs of physicians' practice and in earnings levels.

From the inception of the Medicare program, the AFL-CIO pointed out that the reimbursement formula for physicians was biased in favor of escalation of cost and against adequate cost controls. Reimbursement of physicians based on "prevailing" charges is an open invitation to doctors in a seller's market for medical services to increase their charges so that the new higher level of charges will have to be considered "prevailing." Much better results would be obtained by contractual relationships with providers of medical care and negotiated fee schedules.

Under present law, a Medicare patient can pay the doctor by either of two methods. One is the assignment method and the other direct billing. By the first method, the patient assigns his medical claim to the doctor. He only has to pay the $60 deductible if not previously paid during the year and the doctor receives the remainder directly from Medicare. With direct billing, the patient generally pays the total bill and submits the receipted bill to the "fiscal intermediary" and waits for reimbursement, less deductible and co-insurance.

The advantages of the assignment method seem obvious. The patient avoids the burden of raising large sums of money, which an aged person typically does not have. The doctor fills out a short government form which, because it is standardized, makes for easier administration and is more apt to be filled out correctly given the doctor's experience in filling out such forms.

At first glance, it would seem that everyone would want to use the assignment method. The difficulty is that if the doctor agrees to accept assignment, he also agrees to accept the "reasonable and customary fee" as determined by the Social Security Administration. If he uses direct billing, he may charge what he pleases and the patient has to pick up the difference. The patient finds out how much more he has to pay only after he receives reimbursement from Medicare.

As an alternative to the law's present approach, we urge a negotiated fee schedule. Physicians should then be required to accept such fee schedules in full for services rendered. However, to be fully effective such fee schedules should be applied across-the-board, not just to Medicare. Otherwise physicians would likely raise their fees for private patients, thereby creating two levels of care: one level for private patients and another level for Medicare beneficiaries.

In the interim, pending the development of a fee schedule for the Medicare program, the rising cost situation indicates a need for immediate action. The most desirable and fairest short-term solution is to require doctors to accept assignments and abide by the "reasonable and customary fee." This will insure that cost saving efforts will not be at the expense of poverty stricken older people.

If Congress insists on continuing direct billing, the intermediary at least should publish the "reasonable and customary fee" range for each procedure and that list should be conspicuously posted in the doctor's office. The patient would know at the time he pays the bill how much additional he will have to pay above the "reasonable and customary fee." Now he only finds out sometime after he has paid the bill.

Even effective controls of fees and charges, however, desirable, are not the most effective way of restraining medical care costs. Effective restraint of medical cost escalation will require fundamental changes in the organization, delivery and financing of health care. Eliminating unnecessary hospitalization and surgery, for example, would do far more to reduce the cost of medical care than limiting physicians fees. Since prepaid group practice plans, now generally called Health Maintenance Organizations (HMO), provide better and more comprehensive care at less cost, their rapid development would contribute greatly toward moderating medical costs.

HMO's reverse the financial incentives of physicians. Under fee-for-service, the more treatment the doctor provides the more income the doctor receives. Under a prepaid group practice plan costs are reduced and therefore doctors have an incentive to keep their patients well. This incentive factor is crucial since the doctor plays a central role in the control of health costs.

The doctor determines whether a patient should be hospitalized, how long and the nature of the patient's treatment. The doctor determines how often the patient should be seen, what kind and how many lab tests and X-rays and writes the prescriptions, all too often for costly trade name drugs.

By providing comprehensive care, HMOs avoid twisting patterns of care in the direction of expensive institutional services. The HMO contracts to deliver health services to plan members within the framework of a budget as determined by the contract. Thus, there is a financial incentive to keep the patient will and to avoid unnecessary hospitalization. As a result, such plans have half the hospital utilization rates of what occur under the fee-for-service system.

But we must emphasize that the problems that plague the Medicare program are a reflection of the problems of the whole health care system and cannot be dealt with on a piecemeal basis. Passively spending more dollars, as we are now doing, without making substantial changes in the system will only drive up cost without improving the quality of care. The only satisfactory solution is a national health program. A comprehensive compulsory health insurance program for the whole population offers the best means for providing good health care for all age groups—including the elderly.

Until a national health program is enacted, the government has an obligation in existing programs like Medicare to use the billions of dollars it spends for health care as an economic lever to induce fundamental changes in the traditional, outmoded, and costly methods that prevail in the delivery of health services. This will help to control the costs and improve the quality of health care. In fact, an important prerequisite for establishment of a national health program is to immediately deal with the major deficiencies in the Medicare program. Successful efforts to improve the program will pave the way for higher quality, comprehensive health care for the entire population through a national health program, such as the Health Security program (H.R. 21).

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

We appreciate this opportunity to discuss the very complex issue of physician reimbursement under Medicare. The dental profession was active during the development and initial implementation of the Medicare program and currently provides a significant amount of services, primarily by oral surgeons, under that program. We are vitally concerned with the problems which have developed, with regard to reimbuursement as well as in other areas, and with the efforts which are and will be made to resolve these problems. Above all, we are concerned that the Medicare program provide the best care possible to eligible persons.

In this statement, we will comment on some particular problems which have arisen under Medicare, and more recently under Medicaid, with regard to reimbursement for services provided by dentists. In addition, we will offer our comments on the provisions of H.R. 6699 which was introduced by former Representative Richard Fulton and H.R. 13080 introduced by Representative Duncan.

One of the major concerns of the dental profession with regard to the Medicare program is the current situation which exists relating to the provision of covered services which legally can be provided by both physicians and dentists. Under Medicare there are certain services which dentists are specifically authorized to provide. Dentists are reimbursed for the provision of these services. However, there are other services which dentists are authorized by state licensing laws to perform, but which if provided by a dentist are not reimbursed under the Medicare program, even though physicians are reimbursed for providing the same services. We urge you to amend the Medicare law to provide that those services which a dentist is legally authorized to perform and which are covered under the Medicare program should be paid for by Medicare when provided by a dentist as they would be if a physician had performed them. The existing situation under Medicare is not only inequitable for the dentist who by training and under state law is capable of providing these services, it also reduces the opportunity of choice of provider by patients. We should point out that a similar situation is now arising under the Medicaid program in those states where dental benefits are being reduced.

A second major concern of the dental profession under Medicare involves the payment of hospital costs in cases where a dentist certifies that hospitalization of a patient is needed because of the severity of the dental condition which the dentist will be treating. There are frequent cases, particular with elderly patients, where a dentist may decide that because of the condition of the patient and the severity of the treatment, it is necessary that the patient be hospitalized in order to have access to all the facilities of a hospital. We believe that in those cases where hospitalization is necessary, even though the services actually performed by the dentist are not reimbursable, the costs of such hospitalization should be reimbursed under the Medicare program. An amendment to authorize such payment was adopted by the Congress in 1971, Section 1862(a)(12) of the Social Security Act. However, because of regulations of the Department of Health, Education, and Welfare, the intent of Congress is not being carried out.

Legislation addressing both of the issues which we have discussed above has been introduced by Representative James Corman (D-Cal.) as H.R. 11288. We strongly urge inclusion of the provisions of H.R. 11288 in any Medicare reform legislation which is developed by your committee.

We have attached a copy of our statement which was presented to the Subcommittee on Health of the Senate Committee on Finance on S. 3205, which is identical to H.R. 13080. That statement addressed most of the provisions of that proposal. Our comments in this statement will be limited to those provisions of H.R. 13080 which relate to reimbursement of physicians under Medicare. In addition, we will offer our comments on H.R. 6699. Before discussing these bills, we want to stress that provisions for reimbursement to dentists under the Medicare program should be consistent with those for reimbursement of physicians.

The provisions of H.R. 6699 and of Section 20 of H.R. 13080 are designed in different ways to bring about complete equality or closer equality of allowable reimbursement under the Medicare program for physicians's services regardless of where these services are provided. The primary thrust of these provisions is to make more equal the reimbursement for services provided in rural areas with that allowed for services provided in metropolitan areas.

The American Dental Association is well aware of problems which have been raised because of different payment levels for services which are provided in metropolitan areas as opposed to payment for those same services when provided in rural areas. The Medicare reimbursement mechanism, which is loosely based on the usual, customary, and reasonable (UCR) fee system which is supported by the American Dental Association, has divided the nation into regions for which reimbursement levels are determined. Most states contain more than one region. Although it is true that no argument can be made that a single program should pay the same amount for any given services no matter where provided, it is also true that costs for providing those services do differ from one area to another even within a single state.

We believe that the usual customary, and reasonable fee system reflects differences in reimbursable amounts based on provider costs and other similar factors between urban and rural areas. While preferring the UCR system, we feel that the system being used in the Medicare program, which is inequitable in many ways, does reflect these differences in the cost of providing services. We do not feel that it is appropriate that the lid which is proposed by H.R. 13080 in Section 20 or the single fee schedule system as proposed in H.R. 6699 be adopted.

Although Section 20 of H.R. 13080 would not automatically grant uniform payment for services regardless of where they are provided, it would dictate allowable reimbursement levels under the Medicare program on a basis which is unrelated to the usual, customary, and reasonable charges made by health care providers in the area. The fee schedule system proposed in H.R. 6699 would, although based on recommendations from appropriate professional societies, essentially do away with the UCR concept and establish a system for reimbursement which would have no direct relationship to the costs of providing the services which are reimbursable under Medicare.

Our reading of H.R. 13080 leads us to conclude that Section 20 subparagraph E is a further infringement on the usual, customary, and reasonable charge system in that it reduces the allowable prevailing charge level in states with two or more charge localities from the 75th percentile to the 50th percentile of charges made in the state. This is an unreasonable and improper provision. We fail to understand the reasoning behind this suggested change. We would point out that the placing of arbitrary limits on physician reimbursement might adversely affect the quality and accessibility of care under this program.

The provisions of Section 21 of H.R. 13080 which authorize incentives to accept assignment of claims are restricted to doctors of medicine and osteopathy. These provisions authorize certain administrative and financial incentives to participating physicians who would be defined as physicians who agree to accept assignments for all claims made for treatment of individuals under Part B of Medicare and that the reasonable charge as determined under the Medicare law would be the full charge for services. H.R. 6699 also contains provisions for the use of participating physicians under the program. Participating physicians under H.R. 6699 would agree to accept payment of the fee schedule amount as payment in full for the services provided to all individuals eligible for benefits under Part B of Medicare or under Medicaid.

We feel that the incentives offered in these two bills to participating physicians may be attractive to certain providers. At the same time, we are opposed to the requirement that these provisions apply to all claims or to none at all.

A mandate that all claims be on an assignment basis or on a fee schedule basis could further reduce rather than increase the level of acceptance of assignments by physicians.

We thank you for this opportunity to present our views on proposals addressing the complex area of physician reimbursement under Medicare. In summary, we have particular concerns with current restrictions on reimbursement to dentists for services which are reimbursable under Medicare when provided by physicians. In addition, we are concerned that hospital costs are not paid for under Medicare in cases where the condition of the patient requires hospitalization in order to assure the availability of all potentially necessary treatment facilities. In addition, we have some very real concerns with proposed legislation which will result in a rigid reimbursement structure under the Medicare program which may not be responsive to the actual cost of providing care to Medicare enrollees.

As we have mentioned above, our primary concern is that quality health care be provided to Medicare enrollees. Efforts to modify the reimbursement mechanisms under this program must be tempered by the fact that in no case should there be action taken which will result in a two-tier system of care being provided, one level of care for the general public and another for those eligible under Federal health care programs.

We look forward to working with you and your subcommittee as you continue your deliberations on this important subject.

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION ON S. 3205, THE MEDICARE AND MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT BEFORE THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE, U.S. SENATE

We appreciate this opportunity to discuss this complex legislation which would make major changes both in the administration of, and the methods for determining levels of reimbursement under, the medicare and medicaid programs. The dental profession was active during the development and initial implementation of these programs and currently provides a significant amount of services under each of them. We are vitally concerned with problems which have developed with these programs and with the efforts which are and will be made to resolve these problems. Above all we are concerned that these programs provide the best care possible to eligible persons.

Before addressing specific provisions of S. 3205, we would like to discuss two issues which are of major concern to the dental profession. The first of these pertains to a situation which exists under the medicare law relating to the provision of covered services which legally can be provided by both physicians and dentists. Under medicare, there are certain services which dentists are specifically authorized to provide. Dentists are reimbursed for the provision of these services. However, there are other services which dentists are authorized by state licensing laws to perform but which, if provided by a dentist, are not paid for under the medicare program even though physicians are reimbursed for providing the same services. We urge you to amend the medicare law to provide that those services which a dentist is legally authorized to perform and which are covered under the medicare program should be paid for by medicare when provided by a dentist as they would be if a physician had performed them. Not only is the present situation inequitable for the dentist, it also reduces the opportunity for choice by patients. Legislation to correct this inequity in the medicare law has been inroduced by Representative James Corman (D–Calif.) as H.R. 11288. We should point out that this amendment does not authorize additional medicare benefits, it simply makes the system of reimbursement for covered services more equitable. We strongly urge inclusion of the relevant provisions of H.R. 11288 in any medicare reform legislation which is developed by your committee.

The second major concern of the dental profession is the cutbacks which many states are now implementing in the medicaid program.

These cutbacks, which are supposedly being made in the name of economy, have resulted in reductions or total deletions of adult dental care benefits in at least nine states. We strongly oppose the deletion or reduction of these benefits and are hopeful that mechanisms can be developed to prevent further reductions and to help restore dental benefits to the medicaid programs in those states where these cutbacks have occurred.

One of the effects of this reduction in dental benefits has been the development of a problem under medicaid which is similar to that which we discussed above with regard to medicare. In those states where dental benefits have been eliminated from among those offered under the medicaid program, services which are covered under medicaid if performed by a physician are not considered as covered services when performed by a dentist. Therefore dentists are not being reimbursed for providing these services. Correction of this inequity will not result in additional services being covered under medicaid. Instead correction would result in a much more equitable situation with regard to the provision of services under this program. All that is needed to correct this inequity is legislation providing that dentists be reimbursed for the provision of services which are included under the medicaid program when provided by physicians and which the dentist has the training and authority, under the state practice acts, to perform.

Again we emphasize that correction of this so-called overlap problem under the medicare and medicaid programs can be accomplished by making relatively technical changes in the medicare law and does not require the development of additional benefits under either of these programs. We have attached to this statement a copy of an amendment to accomplish these needed changes.

HEALTH CARE FINANCING ADMINISTRATION (SECTION 2)

The bill calls for the establishment of a separate organizational unit within the Department of HEW to be known as the Health Care Financing Administration. This unit would be under the direction of an Assistant Secretary for Health Care Financing. The unit would include the functions and personnel of the existing Bureau of Health Insurance, Medical Services Administration, Bureau of Quality Assurance and Office of Nursing Home Affairs. The new Assistant Secretary would report directly to the Secretary and would have policy and administrative responsibility for the medicare, medicaid, professional standards review organization and renal disease programs established under the Social Security Act.

The American Dental Association is keenly aware of administrative difficulties which have arisen in the implementation of the various Social Security Act health care programs. We can agree that greater coordination in the implementation of these programs would be helpful. However we are strongly opposed to the creation of an administrative unit which would not be under the specific direction of the Assistant Secretary for Health. It must always be kept in mind that the programs under consideration are health care programs and that it is the delivery of quality health care which is of paramount importance. Although administrative and other improvements can be made, these should always be accomplished under the guidance and direction of those who are responsible for insuring that the programs provide the highest level of care possible. We are very concerned that the establishment of an administrative unit which is headed by an individual of equal position to the Assistant Secretary for Health and which is given policy and administrative responsibility for these health care programs will lead to a decreased emphasis on the quality of health care and an overemphasis on the important, but not overriding, issues of controlling program costs and administration. We would support appropriate mechanisms for improved administrative and other efficiencies in this program, particularly at the operational level. However the overall responsibility for these health care programs must reside in the Assistant Secretary for Health and not in an individual who is primarily concerned with financing and with cost control. We urge that the reforms as specified in Section 2 not be implemented.

OFFICE OF CENTRAL FRAUD AND ABUSE CONTROL (SECTIONS 2 AND 3)

The bill would establish within the Department of HEW an Office of Central Fraud and Abuse Control which would be under the direction of an Inspector General for Health Administration. This Office would have general responsibility for monitoring fraud and abuse control activities of the various Social Security Act health care programs and initiating and conducting direct investigations with respect to alleged, actual, or potential fraud or abuse in these programs.

The Inspector General for Health Administration is given quite extensive and specific authority with regard to control of fraud and abuse. The bill makes clear that the Inspector General is to be under the control of no person in the

Department of HEW other than the Secretary. The Inspector General is to carry out reviews, inspections, and audits of the medicare, medicaid and any other Social Security Act health care programs to determine the extent to which these programs are in compliance with applicable laws and regulations, to make recommendations for the correction of deficiencies in or for improving the organization or other aspects of these programs, and for evaluating the effectiveness of these programs in attaining the objectives and purposes of the provisions of law authorizing them. The Inspector General also is authorized to spend up to $100,000 a year for confidential expenditures to aid his inspections, audits or reviews. A report of these confidential expenditures would be made to Congress.

It should go without saying that the American Dental Association strongly abhors any level of fraud or abuse in these and any other health care programs. We are ready to assist in any appropriate ways in the detection of fraud and abuse and to support efforts of the Department of HEW and of others in eliminating abuse of these programs. However, we are very much concerned with the extent of authority contained in this bill and with the seeming overemphasis on the issue of fraud and abuse control.

We understand that the Department of HEW has recently greatly expanded its own fraud and abuse control activities. We support such efforts. We do not believe that an independent Office of Central Fraud and Abuse Control with the extraordinary authority granted to it and its Inspector General director are necessary or appropriate in view of these already instituted efforts. We urge that the provisions for this Office and for the Inspector General be deleted from S. 3205. We further urge full support for the activities of the Department as it steps up its efforts against fraud and abuse.

STATE MEDICAID ADMINISTRATION (SECTION 4)

The provisions of this section of the bill are salutory in that, if states are able to comply with them, administration of the medicaid program would be significantly improved. Certainly one benefit resulting from the requirements that claims be paid quickly would be an improved cash flow for health professionals. Also it is certain that proper implementation of the requirements for periodic determination and redetermination of eligibility for medicaid benefits would assist in insuring that only eligible persons are receiving medicaid benefits. The information required relating to quality control, claims payment, and utilization of services also could be helpful in the long-term implementation of the medicaid program.

Our concern with these provisions is that they may prove too burdensome for the states to meet, although obviously this is a judgment which can best be made by those who are administering the program. We would be concerned that if the provisions are too strict, resulting in reduced federal payments to the states, this could further result in reductions in the benefits which are offered by the states and/or a reduction of payments under the medicaid program. In either instance the overall effectiveness of the program would be seriously hindered. We are very much concerned that the penalties authorized by this section could be very deleterious to attainment of the overall goals of the medicaid program and believe that a much greater understanding of the ramifications of such penalties should be developed before they are authorized.

CLAIMS PROCESSING BY CARRIERS (SECTION 5)

The provisions relating to procedures for the processing of claims by carriers are ones which in terms of feasibility and resultant improvements in the program are best addressed by representatives of the carriers. However, we reaffirm the need to insure that any legislation which relates to the processing of claims or transfer of medical and other health information include strict and appropriate protection of the confidentiality of these records.

REGULATIONS OF THE SECRETARY (SECTION 7)

One of the major difficulties which we have faced with regard to rules and regulations promulgated by the Secretary of HEW has been a lack of appropriate time for comment on these rules. The current normal procedure is that a proposed rule is published and a comment period of 30 days is allowed. HEW then reviews these comments and promulgates a final regulation which is normally effective upon publication. In many instances the complexity of HEW regulations makes a 30 day comment period completely inadequate. We understand that the Department is implementing changes in the regulation writing process to allow greater input from interested parties. We hope that these changes will be beneficial.

From the language in section 7 of S. 3205, we are not certain whether the provision relates to the minimum comment period which is to be allowed with regard to proposed regulations under the Social Security Act or if it relates to the amount of time which must be allowed between the publication of a proposed rule and its final promulgation. If the language is intended to relate to the latter situation, we would have extreme concerns both in terms of the shortness of comment time which would result and with regard to the rapidity with which HEW would be expected to review and decide upon comments which are made on federal regulations. We are in support of this provision if it is intended that at least a 60 day comment period on proposed regulations is to be required. However we would urge that if this interpretation is correct, the provision be redrafted to clearly reflect this intent.

In addition, we have concern with the requirement in the bill that regulations implementing S. 3205 would have to be promulgated and effective not later than 13 months following enactment of this bill. Although there have been times when the regulation development process has seemed to become bogged down leaving the implementation of various programs in a state of confusion, we would be opposed to a strict time limitation being statutorily mandated for the development of regulations. The development of federal rules and regulations is a complex process, particularly with regard to major legislation such as is proposed in S. 3205. While we commend efforts to assure the expedient development of rules and regulations, we would oppose any provision which mandates that regulations be developed within a time frame which may be unrealistic and may result in a lack of thoroughness in the development of these regulations.

TERMINATION OF HIBAC (SECTION 8)

It has been our belief that the existence of an advisory council to the Secretary for the medicare program, such as the Health Insurance Benefits Advisory Council, which can bring to the Secretary the advice and recommendations of individuals who are involved with the program, is most commendable. With adequate financial and staff support, we believe that this body could contribute more to the solution of problems faced by medicare and other national health programs. We understand that there have been criticisms of the effectiveness of HIBAC but feel that the major problems of this Council are based on a lack of adequate support within the Department of HEW. We recommend that HIBAC be retained and provided with adequate staff and financial support.

CONVERSION OF UNDERUTILIZED FACILITIES (SECTION 11)

Without being able to comment upon the specific mechanics and practicality of such a provision, the Association is in favor of support being provided to institutions to assist them in converting unnecessary, high cost hospital beds to needed, less expensive facilities. We raise the question as to whether the full costs of this conversion are to be met by the federal government or will these costs be allocated to private paying patients of the facility as well?

PHYSICIAN REIMBURSEMENT (SECTION 20)

Before discussing the several sections of S. 3205 which address reimbursement to individual practitioners under medicare and medicaid, we want to stress that provisions for reimbursement to dentists under these programs should be consistent with provisions for the reimbursement of physicians.

The American Dental Association is well aware of problems which have been raised because of different payment levels for services which are provided in metropolitan areas as opposed to payment for those same services when provided in rural areas. The medicare reimbursement mechanism, which is loosely based on the usual, customary, and reasonable (UCR) fee system, which is supported by the American Dental Association, has divided the nation into regions which reimbursement levels are determined. Most states contain more than one region. Although it is true that an argument can be made that a single program should pay the same amount for any given services no matter where provided, it is also true that costs for providing those services do differ from one area to another, even within a single state.

We believe that the usual, customary, and reasonable fee system reflects differences in reimbursable amounts, based on provider costs and other similar factors, between urban and rural areas. While preferring the UCR system, we feel that the system being used in the medicare program, which is inequitable in many ways, does reflect these differences in the costs of providing services. We do not feel that it is appropriate that the lid which is proposed by S. 3205 in section 20 be adopted. Although this section would not automatically grant uniform payment for services regardless of where they are provided, it would dictate allowable reimbursement levels under the medicare program on a basis which is unrelated to the usual, customary and reasonable charges made by health care providers in the area.

Our reading of this bill leads us to conclude that section 20, subparagraph E, is a further infringement on the usual, customary and reasonable charge system in that it reduces the allowable prevailing charge level in states with two or more charge localities from the 75th percentile to the 50th percentile of charges made in the state. This is an unreasonable and improper provision. We fail to understand the reasoning behind this suggested change. We would point out that the placing of arbitrary limits on physicians reimbursement might adversely affect the quality and accessibility of care under this program.

INCENTIVES TO ACCEPT ASSIGNMENT OF CLAIMS (SECTION 21)

The provisions of section 21 of S. 3205 are restricted to doctors of medicine or osteopathy. These provisions authorize certain administrative and financial incentives to participating physicians, who would be defined as physicians who agree: (1) to accept assignments for all claims made for treatment of individuals under part B of medicare, and (2) that the reasonable charge as determined under the medicare law would be the full charge for services. We feel that the incentives offered in this section to participating physicians, may be attractive to certain providers. At the same time, we are opposed to the requirement that this provision apply too all claims or to none at all. A mandate that all claims be on an assignment basis could further reduce, rather than increase, the level of acceptance of assignments by physicians.

MEDICAID PHYSICIAN REIMBURSEMENT (SECTION 23)

It is the Association's position that reimbursement mechanisms, particularly in public programs in which these mechanisms are determining the practitioner's total compensation, should be founded upon the practitioner's usual fee. Acceptance of this principle in the design of a public program is essential to assuring the program's beneficiaries access to the full range of health services available to the community's total population.

Further, the Association believes there should be a single system of reimbursement for all health services. Because benefits provided under medicaid and medicare are not identical, a system which relates one program's determination of reasonable fees for specific services to determinations made under the other is susceptible to the creation of certain inequalities, and therefore is undesirable despite the probability of its providing increased levels of reimbursement for many services under the medicaid program.

We thank you for this opportunity to present our views on this most complex and comprehensive proposal. In summary, we have particular concerns with current restrictions on reimbursement to dentists for services which are reimbursable under medicare and medicaid if provided by physicians. Beyond that we are in support of many of the goals contained in this legislation although we feel that some of the drastic administrative and other steps which are proposed are not needed and that these goals can be met through the Department of HEW under the direction of the Assistant Secretary for Health.

Suggested American Dental Association Medicare and Medicaid Amendments

The following suggested amendments are designed to assure that services provided by physicians which are covered under either the medicare or medicaid programs, or both, which also can be provided legally by a licensed dentist are treated as covered services under those programs when provided by a licensed dentist. Section (1) of these amendments is based on Section (1) of H.R. 11288 which was introduced by Rep. Corman (D-Calif.).

Section 1.—That clause (2) of section 1861(r) of the Social Security Act is amended to read as follows: "(2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function or action, and who is acting within the scope of his license when he performs such function or action, or for purposes of the certification required by section 1814(a)(2)(E) of this act, or"

Section 2.—Section 1905(a)(5) of the Social Security Act is amended by deleting the phrase "as defined in section 1861(r)(1)" and inserting in lieu thereof "as defined in section 1861(r)(1) except that physicians services include, and reimbursement shall be made for, those services for which reimbursement will be made when provided by a physician and which may be provided by a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the state in which he performs such services and who is acting within the scope of his license when he performs such services.

STATEMENT OF THE AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

I. INTRODUCTION

The American Society for Medical Technology (ASMT) is most pleased to provide the members of the House Ways and Means Health Subcommittee with our views concerning physician reimbursement practices under the Medicare and Medicaid programs.

ASMT is a national, professional organization composed of over 27,000 members engaged in the delivery of clinical laboratory services. The Society is composed of 50 constituent state societies, in addition to the District of Columbia, which hold charters granted by the national organization. The country is divided into ten regions with an average of five states per region. An elected House of Delegates forms the governing body of the Society and when not in session, its functions are carried out by an elected Board of Directors. The Society is organized to give each member the opportunity to be an active partner in the development of standards and practices enumerated in ASMT's policies, positions, and publications.

Our membership is made up of a variety of nonphysician categories of clinical laboratory personel including clinical laboratory administrators, supervisors, educators, technologists, technicians, assistants, and such specialists as microbiologists, clinical chemists, hematologist, immunohematologists, cytotechnologists, histotechnologists, and nuclear medicine technologists.

Approximately seventy-five percent of our membership hold degrees at or above the baccalureate level while another ten percent hold associate degrees. The remainder of the membership is composed of individuals who fall in specified categories such as students.

The Society is actively involved in both the areas of accreditation and certification. ASMT cooperated with the American Society of Clinical Pathologists (ASCP) in establishing the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) which is an autonomous agency responsible for the accreditation of education programs for clinical laboratory personnel. The society currently participates with ASCP in the certification of clinical laboratory personnel through a Board of Registry.

In addition to a membership diverse in specialty and generalist functions within the laboratory field, laboratory settings or places of employment range from private or independent laboratories to physician offices, clinics, blood banks, research institutes, to hospital laboratories—both governmental and non-governmental. Thousands, in fact the majority, of our active members work in hospital laboratory settings throughout the country.

On behalf of our membership and in the interest of better health care delivery on a national basis, ASMT is in favor of and has previously gone on record to support the concept of national health insurance. Our Society subscribes to the basic principle that every American should be assured access to quality health care and that no person should be denied health care because of inability to pay.

In testimony on national health insurance presented before the House Ways and Means Committee in May of 1974, ASMT suggested the obvious: that any form of national health insurance adopted by the Congress will undoubtedly have a profound effect on the way health care is now delivered. In fact, close scrutiny and evaluation of our present health care system is critical in order that any form of NHI eventually developed will ensure both efficient and economical health care services to all our citizens.

Although we continue to favor eventual enactment of a well-conceived national health insurance program, ASMT recognizes that the critical problem of controlling the sharp rise in health costs has effectively slowed the drive toward some form of NHI during this session. Moreover, while the current health care system contains acknowledged strengths, an examination of the Medicare program since its enactment clearly demonstrates serious defects which must be eliminated before moving on to a more comprehensive health insurance scheme. The argument for scrutiny of the present Medicare program was underscored by the recent hearings on S. 3205 held by the Senate Finance Health Subcommittee. Testimony presented before the panel stressed the inadvisability of building upon the current health system until some of the obvious deficiencies within the system can be eliminated. Therefore ASMT is encouraged by the focus of these Subcommittee hearings—physician reimbursement practices under the Federal health insurance programs—and is pleased to provide comments on Mr. Duncan's related proposal for amending the Social Security Act, H.R. 13080.

II. HOSPITAL ASSOCIATED PHYSICIANS

Section 22 of H.R. 13080 would amend the Social Security Act by distinguishing between physicians' services of an educational executive, or research nature and those personally performed or directed for the benefit of a patient and which are customary and appropriate. Since a special definition would be applicable to pathology services which defines "physician services" to exclude services performed in carrying out responsibilities for supervision, quality control, and for various other aspects of a clinical laboratory's operation customarily performed by nonphysician personnel, ASMT is able to provide the Subcommittee with some background information reflecting the scope of duties which are presently performed by nonphysician personnel in the clinical laboratory.

Medical technologists, possessing a broad background in basic and applied clinical sciences, perform four major roles within the hospital laboratory setting. The survey was directed and conducted by the Personal and Professional Development Division of ASMT in the fall of 1975. The respondents to the survey totalled 1,292 ASMT members who hold the position of Administrative Technologist or Chief Technologist, with the nationwide distribution of the survey population representing various places of employment, size of institution, geographical regions, and urban and rural settings. A summarized copy of the study including statistical analysis is attached to this statement.

According to the distribution by place of employment, 61 percent of the respondents were employed in hospitals. Thirteen percent of these were located in 1–99 bed hospitals; 26 percent in 100–299 bed hospitals; and 22 percent in hospitals of 300 or more beds.

Given the expansion of health care services over the past decade, and the associated changes within the medical laboratory, which include increased testing, technological improvements, and changes in roles and functions of certain personnel, the study sought to determine the degree of involvement of medical technologists in the critical areas of management and supervision. The ASMT laboratory management survey clearly indicates that medical technologists are now playing a central role in laboratory management. In fact, according to these data, the administrative medical technologist carries out a majority of the laboratory's administrative functions.

Supervisors plan, organize and delineate the duties and responsibilities of personnel working under their direction. They assume the responsibility of instigating new procedures, and establishing and maintaining quality control programs. They train presonnel, maintain supplies and disseminate information from their department to other members of the laboratory staff. They also maintain procedural directions and ascertain the reliability of test results issued from their departments. Supervisors are also responsible for responding to complaints concerning their departments.

Medical technologists are unquestionably involved in supervising the planning, processing and reporting of laboratory tests. The degree of involvement depends upon the organizational structure of the institution. In the smaller hospitals, the supervisor's duties are all inclusive and even in the largest medical complex the medical technologist maintains supervisory responsibilities of departments within the laboratory. These nonphysician functions are commonly established and accepted by hospital administrations.

Role of the Chief or Administrative Technologist in Laboratory Management.—On December 30, 1975, ASMT issued a Report on a Laboratory Management Survey to document which administrative functions are carried out by the medical technologist holding an administrative level position in the clinical laboratory diagnostic testing procedures essential to the diagnosis of a patient's medical condition. In addition to routint testing across a broad range of laboratory procedures, medical technologists also perform complex testing in a variety of specialized areas such as microbiology, parasitology, serology, hematology, clinical chemistry, urinalysis, and immunohematology. Secondly, technologists fulfill the duties and responsibiities of technical supervisors, in both the generalist and departmental/section areas. Thirdly, the Chief or Administrative Technologist assumes a variety of managerial responsibilities within the hospital laboratory. Finally, the medical technologist also plays a direct role in the educational process of clinical laboratory personnel. At this point it would be useful to more clearly define the supervisory, administrative and educational functions of the medical technologist as an indicator of nonphysician involvement in clinical laboratory operations.

Role of the Medical Technologist in Laboratory Supervision.—In the majority of hospitals, medical technologists have traditionally served as technical supervisors of the total laboratory as well as technical supervisors of designated, specialty departments/section areas. Supervisors usually work under the direction and in cooperation with the administrative technologist or chief technologist.

Thirty-three administrative functions common to the medical laboratory were listed on the survey questionnaire. The functions listed ranged from who "interviews prospective employees," to who "evaluates electronic data programs and reports." To aid in reporting the survey results, the functions were separated into three categories of Personnel Management; Clinical Services Management; and General Laboratory Management. Table I on Page 25 lists the administrative functions, as categorized.

Five choices of who carries out the functions were available on the questionnaire, consisting of:

(1) Administrative Technologist, Chief Technologist, or Laboratory Manager.
(2) Administrative Technologist *and* Director of Laboratories—joint function.
(3) Director of Laboratories.
(4) Does not apply to my situation.
(5) Other (please specify).

The report summarizes functions carried out by four groups in the medical laboratory which may be found in Table II on Page 16.

In sum, the 1,292 medical technologist respondents report that they carried out, on an average, 17.6 or a majority of the 33 listed administrative functions. They report that the Directors of Laboratories on an average, carry out 2.6 of the 33 functions; the medical technologist and director jointly carry out an average of 7.9 functions; and hospital administrators carry out 1.8 functions.

Thus for the 1,292 questionnaires analyzed, Chief and Administrative medical technologists have a significant involvement in a wide range of the administrative functions carried out in the medical laboratory. While the respondents' involvement ranges from an average of 88 percent who "schedule laboratory personnel" to 20 percent who "establish charges for laboratory tests," the responses are remarkably consistent across the major categories of places of employment and the ten geographical regions.

Medical technologists employed in hospitals with less than 300 beds have the highest average direct involvement in the functions of "reviewing and approving new laboratory methodologies"; "selecting the appropriate testing program"; "maintaining laboratory systems"; and "selection of equipment to purchase" for all grouped places of employment. Their average direct involvement for all listed functions in hospitals of 1–99 beds is 61 percent while the average for all places of employment categories is 54 percent.

Role of the Medical Technologist in Medical Technology Education.—While the essentials for Medical Technology Programs prepared by the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS), require sharing of responsibility between the medical director and the medical technologist program director for the organization and administration of the program, the guidelines outline the medical technologist's duties as follows:

"6. Duties of the program director: In consultation with the medical director, education coordinator and senior faculty he should be responsible for overall direction of the program. With the assistance of appropriate committees he should provide leadership in development and implementation of:

1. Program objectives.
2. Admission policies.
3. Curriculum development.
4. Evaluation procedures.
5. Promotion of students.
6. Recruitment.
7. Public relations (including preparation of catalogues and brochures relating to the program).

He should maintain student records and participate in the student services such as counseling and recruitment.

He should attend at least one workshop or one course related to education each year."

It can be seen therefore that the medical technologist plays the primary role in the medical technology educational process. Moreover, it should be noted that significant educational activity occurs within the hospital. For example the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) indicates that as of May 21, 1976, the approved medical technology student capacity stood at 7,736 in over 650 AMA accredited hospital programs. This compares with a student capacity of approximately 1,856 in university-based medical technology programs. The medical technologist, usually entitled an Educational Coordinator in the hospital setting, is in reality if not in title, in most instances, the individual most directly responsible for the education of medical technology personnel within the hospital. As Table III, on page 17 demonstrates, the medical technologist is involved in the overwhelming majority of the nineteen roles listed for the medical technology education program. This table is based upon review of the duties and responsibilities of a representative sample of medical technology education coordinators. For certain roles, it will be noted that both the physician and the medical technologist are jointly involved while there are few roles performed exclusively by physician personnel.

As the Committee evaluates current Medicare reimbursement provisions in the hospital setting, the Society believes it is extremely important to carefully examine the actual functions and roles performed by hospital personnel. In this regard, we note that under the provisions of section 22 of H.R. 13080, personal patient services (physician services requiring direct personal physician involvement) would be allowable on a fee-for-service basis. In accordance with the College of American Pathology's definition of "educational" and "executive" functions performed by the physician, the bill would allow reasonable overall compensation related to the time and effort spent by the physician in the performance of these functions.

Realizing that this is an area of major concern for our physician colleagues, ASMT would like to go on record in stating that we believe that the majority of hospital based physician specialists do not abuse the current reimbursement process. It appears that the very process itself is the crucial issue and we can therefore appreciate the Committee's determination to carefully evaluate this important area. Since functions vary depending on the size of the institution it is difficult to assign exact percentages regarding degrees of responsibility for the many functions performed by both physician and nonphysician personnel in the clinical laboratory.

Regardless of the reimbursement system however, ASMT supports the concept of fairly compensating personnel based upon their personal professional effort and amount of time spent in the performance of specified functions. In this time of escalating health care costs, we do not believe the interests of the American public are best served by any other approach.

III. CONCLUSION

ASMT appreciates this opportunity to provide the Subcommittee with this information and we request that this statement be made part of the official hearings record. We commend Chairman Rostenkowski for initiating these hearings during the 94th Congress and believe that H.R. 13080 offers a significant opportunity to reevaluate certain critical reimbursement issues related to the Medicare and Medicaid programs.

TABLE I.—CLINICAL LABORATORY ADMINISTRATIVE FUNCTIONS

Personnel management functions	Clinical services management functions	General laboratory management functions
Schedules laboratory personnel	Selects and authorizes expendable supplies.	Prepares statistical reports for laboratory.
Counseling of personnel	Authorizes reagent purchases	Prepares or selects laboratory report forms.
Provides in-service orientation	Maintains a laboratory safety program.	Administers the laboratory budget.
Interviews prospective employees	Selection of equipment for purchases	Prepares the laboratoty budget.
Conducts regular personnel meetings	Maintains preventive maintenance program.	Determines laboratory space allocation.
Determines merit or salary increases	Authorizes equipment purchases	Establishes charges for laboratory testing.
Determines personnel policies in accordance with employer policies.	Selects appropriate proficiency testing program for use.	Represents laboratory in inter- and/or intra-departmental operations.
Determines base salary level for employees when they are hired.	Reviews and approves new methodologies (techniques and/or tests).	Maintains laboratory cost accounting and cost analysis program.
Conducts performance evaluation sessions with employees.		Evaluates electronic date programs and reports.
Determines academic and experience qualifications for each position.		
Selects qualified prospective employees		
Authority to fire employees		
Determines employees' promotions		
Determines academic and experience qualifications for each position.		

TABLE II.—SUMMARY OF THE FUNCTIONS CARRIED OUT BY 4 GROUPS IN THE MEDICAL LABORATORY

[In percent]

	Personnel management	Clinical services management	General laboratory management
Medical technologists (respondent)	57	55	47
Director of laboratories	7	9	8
Joint function of technologist and director	23	26	24
Does not apply	4	2	10
Hospital administrator	5	4	7

TABLE III.—ROLES IN MEDICAL TECHNOLOGY EDUCATION PROGRAM

	Medical technologist only	Physicians only	Medical technicians/ physicians
1. Development/review of curriculum	X		X
2. Development of criteria for student selection	X		X
3. Selection of students according to criteria	X		X
4. Development of program philosophy, goals and policies	X		X
5. Provision for medical relevance			X
6. Provides general orientation to multiple facets of the profession such as:	X		X
Medical ethics			
Legal liabilities			
Relationship to patient and health professionals, etc			
7. Development of educational objectives and determination of acceptable levels of competence for all areas.	X		
8. Development and implementation of all necessary schedules and rotation for attainment of educational objective.	X		
9. Schedules and supervises lectures, lecture content and practicum activities necessary for attainment of educational objectives.	X		
10. Development, review and evaluation of oral, written and practical examinations for use in determining student performance	X		X
11. Evaluation of student's progress toward attainment of educational objectives	X		
12. Counsel students in various areas: career choice, performance, attitude, etc	X		X
13. Teaching (lectures and/or practical):			
A. Students			
B. Peers			
C. Faculty			
D. Physicians, interns and residents			

See footnotes at end of table.

TABLE III.—ROLES IN MEDICAL TECHNOLOGY EDUCATION PROGRAM—Continued

	Medical technologist only	Physicians only	Medical technicians physicians
14. Development of cooperative activities between affiliated academic and clinical facilities, including service on designated committees	×	----------------	×
15. Answering written and oral inquiries related to the educational program	×	----------------	
16. Maintaining continuing competence in educational principles and practices and/or specific technical area(s)	×	----------------	×
17. Preparation of budget(s) for educational program	×	----------------	×
18. Employment of personnel to be involved in educational program	×	×	×
19. Procurement of external funds for educational programs (writing of grants for Federal, State and private support)	×	×	×

Note: When medical technologist only and medical technologist/physician both are checked, this reflects the variety of approaches which are in practice within existing educational programs. This is due to the variance of educational programs and their administrative structure.

Who Says Med Techs Don't Make Management Decisions?

Just exactly how much authority does the medical technologist have as an administrator? An ASMT survey says "plenty"

by Mary E. Buxton

NOTE: The percentages reported in the accompanying figures are based upon the total number of questionnaires tabulated for this survey: 1292. However, not all of the percentages add up to 100 due to rounding, as in the case of Figure II. The discrepancy could also be due to the nature of the function, as in Figure III, Figure IV, and Figure V. Percentages were given for only those functions actually performed by the respondent alone, by the respondent as a joint function with the laboratory director, and by the director of the laboratory alone. In almost all cases, there were some respondents who reported one or more functions as being performed by personnel other than the above or who reported the function as not applicable. For example, in Figure III, the bottom entry concerns the determination of salary levels, and in military and governmental facilities these levels are usually set by civil service agencies. In Figure V, tasks related to cost accounting and data processing were often cited as being performed by departments set up for that purpose, such as those in large hospitals. In such cases, the function did not apply to the laboratory. In the summary (Figure VI), these situations are taken into account and even then there were exceptions. The category "other" is composed of such exceptions, which included missing responses (not filled in), functions carried out by the respondent and someone other than the laboratory director (such as a section head), and any response that was not crystal clear.

According to a nationwide survey of American Society for Medical Technology members holding the position of administrative technologist or chief technologist, an average of 18 out of 33 administrative functions are performed almost exclusively by the administrative technologist, and eight more are joint responsibilities of the administrative tech and the director of the laboratory. Three more are performed by lab directors alone, two by hospital administrative personnel, and two by varied members of hospital staffs.

In other words, as many as 26 of the 33 administrative functions listed in the survey questionnaire in the categories of management of personnel, general laboratory services, and clinical services are performed by a medical technologist either alone or jointly with the lab director. Thus, a full 79 percent of functions such as preparing budgets, hiring and firing, selecting equipment, maintaining safety and quality control programs, and reviewing new techniques and methods involve the med tech either as the sole administrator or in conjunction with the lab director.

We are reminded, however, as we approach the IAMLT/ASMT Joint International Conference in Chicago, that the motto, "One Out of Many," refers not only to one gathering of many scientists, but to the fact that every bit of research or progress is the result of many efforts. Decisions made by administrative personnel almost always depend upon the input of many individuals, including supervisory personnel, hospital staffs, and other clinical laboratorians. However, the responsibility for those decisions must rest somewhere. And the survey was designed to elicit that information. The 33 administrative functions could be described as responsibility areas.

Nearly 1,500 ASMT members in the management positions mentioned above responded to the detailed questionnaire. By the cutoff date of November 18, 1975, 1,292 completed questionnaires had been received and were tabulated for this report. (Latecomers were not included.) The size of the surveyed sample and the representative distribution of the respondents among the various places of employment and geographical regions support the conclusion that, in most medical laboratories, the administrative technologist performs a majority of the listed administrative functions.

The survey was originally conceived as an effort to develop a data base on the true role of administrative technologists, and the Personal and Professional Development Division of ASMT was directed to carry it out and report on the findings. Among the reasons prompting the study were the increasing importance of the medical technologist's concern with legislation to improve the laboratories; the technological advances within the laboratories themselves, and the increasing specialization within the profession; the growing number of graduate-degree programs for medical technologists (a sizable number of the respondents hold master's degrees); and the emergence, so to speak, of medical technology as a vital component in the overall delivery of quality health-care services. The tremendous growth of ASMT membership alone over the past decade (from 11,822 to 26,582) would indicate the high regard that medical technologists have for the achievements — and concerns — of their profession.

To be absolutely fair, we admit to a possible vested interest on the part of the respondents to the survey. However, the same limitation would hold true for any

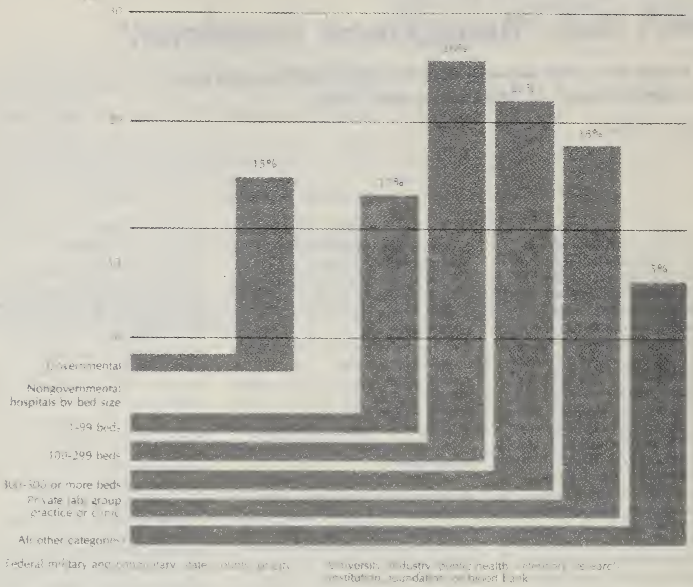


Figure I
Distribution of Respondents by Place of Employment

survey conducted by a professional association of *its own members*. While we believe in the validity of these results, we would welcome a verification of our findings by a disinterested group (such as a team of industrial psychologists or management consultants who are specialists in standard job-analysis techniques). This type of verification is costly, because it should be accomplished by the gathering and integrating of relevant data from the questionnaires as well as by observation and personal interview.

If there is a challenger out there among the readers of this survey, we say, "Great . . . have at it." Considering the huge amount of time and effort being put into the laboratory improvement bills on Capitol Hill, this follow-up would serve to pinpoint the functions actually being performed by medical technologists in administrative posts and would have a direct bearing on the qualifications of personnel in laboratory management. Competency must be determined by the requirements of the job.

ASMT has already declared its own war on incompetency by being very vocal on national health issues and by finalizing an entire series of competency statements on clinical laboratory personnel. These statements will be presented to the 1976 House of Delegates this June, and are the result of much effort by ASMT's committee on competency delineation, the state review teams on competency, and the Scientific Assembly review teams. Also, the Society's laboratory administration section of the Scientific Assembly subcommittee on job titles and job descriptions has prepared detailed material for presentation to the delegates.

In addition to the information requested by the survey, we also uncovered a wide variation in how laboratories are organized. Although there are surprisingly few differences due to regions or types of facilities, there is definitely a difference due to management style. This is true of large or small laboratories. While the survey was anonymous, many respondents signed their names and quite a few sent comments and letters. The following excerpts, taken from those letters, attest to different styles of organization:

- "This is a small 25-bed rural hospital. We have three technologists (degree and license) including myself, a chief technologist. We have a consulting pathologist but not a pathologist director. I have been with the hospital for 18 years and am given wide latitude in my authority."
- "Please note that our management

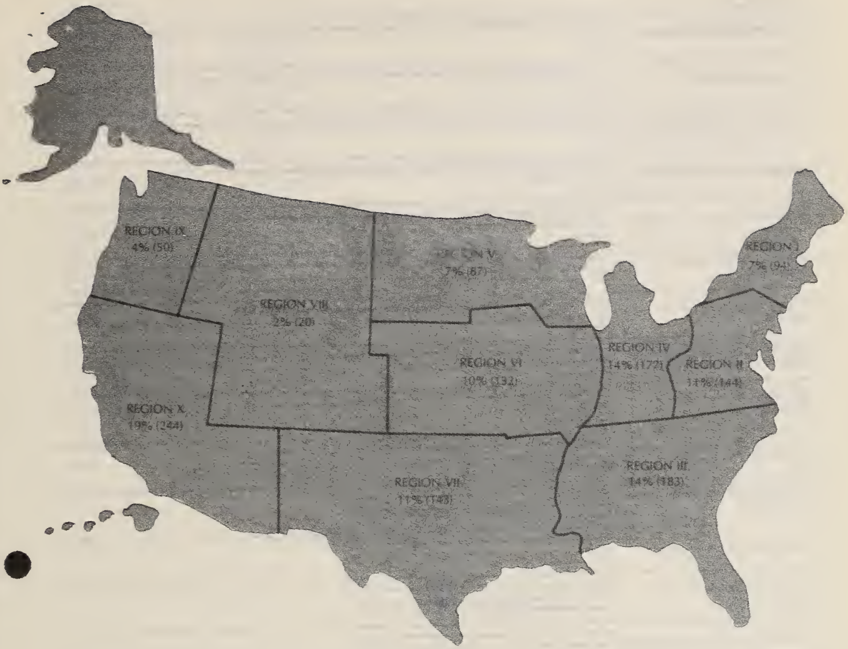


Figure II
Geographical Distribution of Respondents by ASMT Regions

decisions are a collective effort with a high degree of involvement on the part of our section supervisors. In all cases one would have to say that the final authority rests with the laboratory director. His decisions are made based on input from his supervisory technical staff. My job, in brief, is to coordinate all of this activity. Very little *actual* direction or supervision is provided by the director."

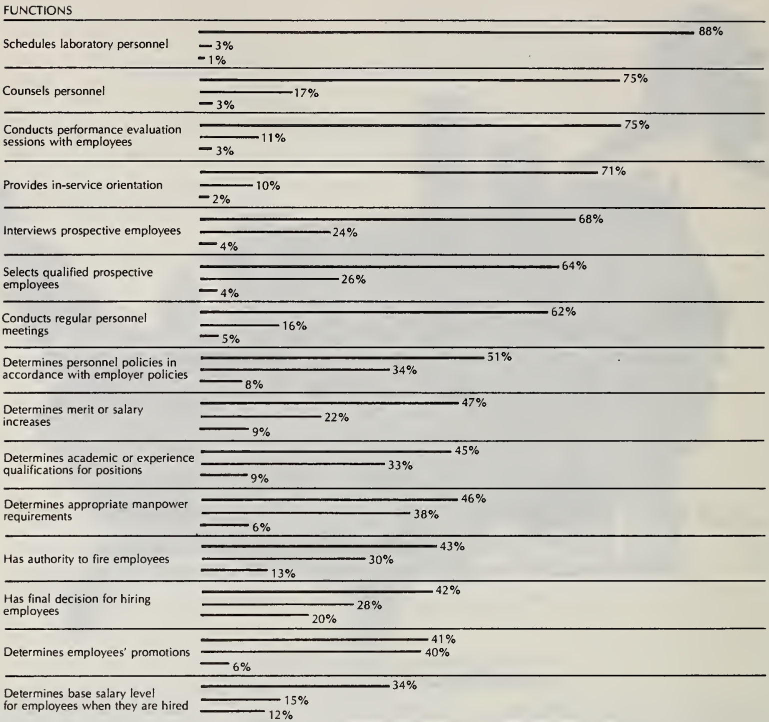
- "My job description in a nutshell is to carry out the pathologist's and hospital administrator's wishes using the resources (including personnel) which they provide me with. Your questionnaire did not appear to consider the hospital administrator as playing this influential a role. However, in the two hospitals I have worked in since my training, the administrator has had, for all practical purposes, a more influential role in the operation of the laboratory than the pathologist. I bring this up just to make you aware that this situation does exist."

- "The lab director/pathologist and I work together . . . at the present time we are in the process of building a new laboratory and I've been given the responsibility of planning and furnishing the lab (subject to his final approval). I have worked closely with the architect and engineers and, while keeping the lab director aware of major decisions, he's leaving things pretty much up to me. How many chief techs ever get the opportunity to have a lab just the way they want it?"

And finally, from a very large 10-hospital system with a centralized purchasing and system-wide standardization, as well as having all personnel below the registered med tech level governed by collective bargaining agreements, comes this comment:

- "The administrative technologist and myself (chief technologist) have performed in our respective capacities since April 1975 *without* an active director of laboratories. All questions answered as "joint function" are in reference to earlier time periods. Presently, we are assuming all responsibility for laboratory function with some aid from hospital administration when necessary."

In spite of the variety in management styles, as shown by the comments above, the results of the survey do indicate the wide range of involvement of med techs in the decision-making process. In the following summaries of the data collected by this survey, individual differences in management tend to disappear. However, while they do exist, the involvement of administrative and chief technologists in the functions described remains surprisingly uniform. Not only



Percentage of administrative functions performed by the medical technologist (respondent) alone, jointly with director of the laboratory, or by the lab director alone.

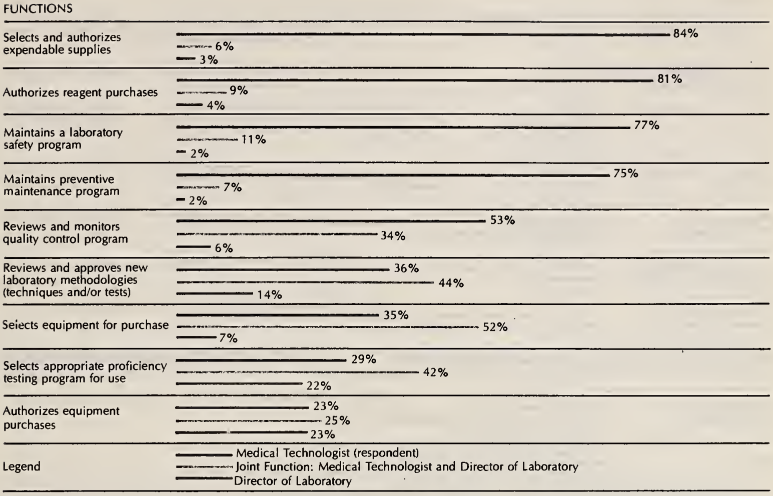
Figure III
Personnel Management

are med techs performing a high percentage of administrative functions, but they are performing them across the nation in all types of facilities and under many different circumstances. (The full report is available through the ASMT Executive Office.)

Methods

The survey sample population was defined as those ASMT members who had designated on their Society membership applications and yearly renewal forms that their job title was administrative or chief technologist. In addition, respondents were asked to answer the questionnaire *only* if they currently held the position of administrative tech, chief tech, or laboratory manager. The last category was added in an effort to include those technologists who may have varying job titles but perform administrative functions at the management level. Furthermore, in order to confine the sample population to the highest level of administrative personnel, ASMT members who have the job title of supervisor or senior technologist were not included in the survey. The membership totals for administrative tech and chief tech were 978 and 2,160, respectively. After removing those members who reside in foreign countries, and with one known

Continued on page 16



Percentage of administrative functions performed by the medical technologist (respondent) alone, jointly with director of the laboratory, or by the lab director alone.

Figure IV
Clinical Services Management

undeliverable questionnaire, the sample population came to 3,074.

The survey materials were mailed October 24, 1975. By the cutoff date of November 18, 1,345 questionnaires had been returned for a total response rate of 44 percent. The 53 incomplete questionnaires reduced the tabulated and analyzed total to 1,292. By December 15, an additional 85 questionnaires came in, for a final response rate of 47 percent.

A small subsample was selected to receive a second mailing of survey materials and follow-up telephone interviews in order to identify possible reasons for nonresponse. The findings of this procedure showed no evidence of bias due to nonresponse, which would lower the number of administrative functions performed by respondents. One-third of the subsample did not currently hold the position of chief or administrative tech. If this finding can be inferred to the entire sample, the response rate would become 57 percent of those currently holding these positions. A second procedure to test bias due to nonresponse was the comparison of the first 40 questionnaires received with 43 of the late arrivals which were not tabulated. This procedure disclosed very similar responses on both sets of questionnaires, thus obviating the possible assumption that the earlier arrivals performed more administrative functions and therefore had a greater interest in the survey.

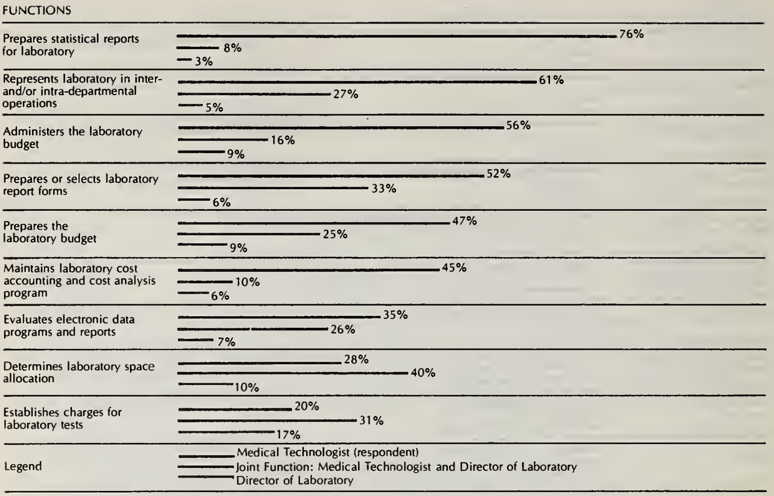
The questionnaire listed 33 administrative functions common to the clinical laboratory (see Figures III to V) as well as a limited number of standard demographic questions. The respondents were asked to designate whether they performed the listed function, whether it was a joint responsibility with the laboratory director, or whether it was the responsibility of the lab director alone. In addition, the respondents could specify personnel other than the above who perform the function or if the function did not apply to their particular laboratory.

Although respondents' anonymity was assured, 424, or 33 percent, did sign their names and, in many cases, enclosed attachments (such as job descriptions) and comments.

The Statistical Package for the Social Sciences (SPSS) computer procedure was used for tabulation and statistical analysis. Kent L. Tedin, PhD, of the Department of Political Science at the Univeristy of Houston, assisted in the computer program design and produced the final survey tabulations.

Respondent Profile

Figure I shows a representative distribution of respondents among five of the six grouped places of employment. The highest number, 335, or 26 percent, designated they are employed by a non-



Percentage of administrative functions performed by the medical technologist (respondent) alone, jointly with director of the laboratory, or by the lab director alone.

Figure V
General Laboratory Management

governmental hospital of 100 to 299 beds. The smallest number, 64, or five percent, are employed by a university, industry, public health or veterinary facility, research institution, foundation, or a blood bank. Fifteen percent are employed by federal, state, county, and city governments; 13 percent in nongovernmental hospitals of less than 100 beds; 22 percent in large hospitals; and 18 percent in private labs, group practice, or clinics.

Geographical distribution of the respondents roughly compares to ASMT's membership distribution and returns came in from all states. Figure II gives the number of actual respondents and the percentages of the total broken down by the 10 ASMT regions.

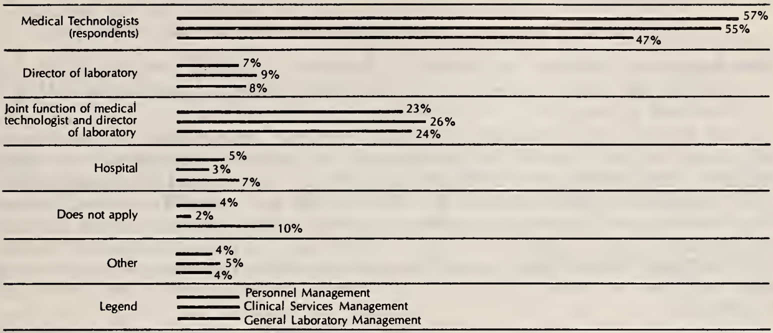
The respondents are well educated and have had extensive experience. Sixty-eight percent have baccalaureate degrees and an additional 12 percent have master's degrees. Of those employed by hospitals with 300 or more beds, the number of respondents holding master's degrees rises to 17 percent. A majority of the respondents, or 58 percent, have served as administrative technologist, chief technologist, or laboratory manager for seven years or longer.

Findings

The significant involvement of the medical technologist in administrative functions contrasts to the low involvement of the laboratory director, as reported on the questionnaires. The responses were remarkably consistent across the demographic and employment categories. Administrative functions were divided into three management responsibility areas in order to compare the level of involvement for personnel management, clinical services management, and general laboratory management. Figures III, IV, and V chart the functions carried out by the technologist, by the lab director, and by the two together as a joint responsibility for each of the three management responsibility areas. The percentages for all of the 33 functions have been combined in Figure VI.

It was found that the degree of involvement varied little among personnel, clinical services, and general laboratory management. For example, the average percent of the functions carried out by the medical technologist alone were 57 percent, 55 percent, and 47 percent, respectively. For the laboratory director's involvement in the functions as a sole responsibility, the figures were seven percent, nine percent, and eight percent for the same areas.

For most of the functions listed, less than 10 percent indicated that personnel other than the technologist or laboratory director performed the function. How-



Combined percentages for all administrative functions performed by the medical technologist (respondent) alone, jointly with the director of the laboratory, or by the director of the laboratory alone. Also included are those functions attributed by respondents to hospital personnel outside the laboratory and those functions which respondents reported "did not apply."

Figure VI
All Administrative Functions

ever, there were a few sharp deviations from this pattern. For example, a full 26 percent reported that the hospital administrative staff determined base salary levels for employees when hired, 20 percent indicated that hospital administrative personnel make the final authorization for equipment purchases, and 15 percent indicated the hospital staff established the charges for laboratory tests. Those functions which did not always apply to the laboratory management team were evaluation of electronic data programs and reports, 25 percent; maintaining cost accounting and cost analysis programs, 18 percent; and conducting regular personnel meetings, 12 percent.

Not surprisingly, respondents credited laboratory directors as actually performing such functions as authorization of equipment purchases, 23 percent; final decision for hiring, 20 percent; and establishing charges for laboratory tests, 17 percent. What is surprising is the converse, that the medical technologist — either alone or as a joint responsibility — is involved in the same functions 48 percent, 70 percent, and 51 percent, respectively.

Direct involvement of medical technologists falls below an average of 40 percent in only eight of the listed categories, four of which are in the clinical services area. It is highest in the personnel management functions such as scheduling laboratory personnel. Other functions most frequently performed by the med tech are authorizing reagent purchases and maintaining laboratory safety programs, both in the over-80 percent range.

The survey results were broken down in the full report by place of employment as well as responsibility area, so that for each of the six categories of place of employment there are three charts according to personnel, clinical services, and general laboratory management. It was found that medical technologists employed in small hospitals (1 to 99 beds) have the highest average involvement in administrative functions, 61 percent, while the average for all places of employment is 54 percent. As would be expected, respondents from large hospitals of 300 to 500 beds were less directly involved in such functions as reviewing and approving new laboratory methodologies and selecting the appropriate proficiency-testing program. However, fully one-third of those administrative and chief technologists in large hospitals reported they authorize equipment purchases.

If the findings of this survey are as valid as we believe them to be, then the medical technologist is, in the majority of laboratories across the nation and in every kind of facility, involved in major decision-making either alone or as a joint function. Therefore, it would follow that ASMT has a great stake in the future of legislation and is bound by conscience and involvement to pursue whatever course will lead to improvement in laboratory performance and better patient care. The Society's visibility on Capitol Hill, and in all areas where health issues are discussed, is directed toward this end and cannot be construed solely as an effort to improve the status of the medical technologist. Obviously, that status is already much higher, insofar as laboratory management is concerned, than may be realized generally.

Such concerns as continuing education, proficiency testing, competency standards, inspection of laboratories, and overall quality assurance are very much the realm of the American Society for Medical Technology today and in the future. As membership in the Society continues to grow, with an increasingly greater emphasis on the professionalism of the technologist, the responsibility for the laboratory's part in the delivery of quality patient care rests as much on the shoulders of the medical technologist as it does on the shoulders of any other medical professional. If not more.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

INDIVIDUAL PATIENT ASSIGNMENT OPTION UNDER MEDICARE

The American Society of Internal Medicine (ASIM) continues to support strongly the preservation of the individual patient assignment option under Medicare

Many reasons exist for this position. First, the major impact of an all-or-none assignment option will be on the delivery of primary care services to Medicare patients. This is because the Medicare program has perpetuated the unfair disparity between reimbursement for procedures and reimbursement for medical judgements (i.e. diagnosis, non-procedural therapy, determination of need for procedural therapy, patient education—services usually provided in the ambulatory setting). Unless this disparity can be corrected, many primary care physicians will be required (in order to survive economically) to choose not to participate.

Second, when physicians opt against participation, even more patients will be forced to fill out the difficult claim forms. This, along with the tendency of patients to save small bills over an extended period of time and submit them en masse, will undoubtedly increase the administrative problems of Medicare Intermediaries. Therefore, the hardships resulting from a change to an all-or-none assignment option will fall more upon the elderly patients and the intermediaries than on the medical profession. Although such a change could significantly lessen the physicians' office administrative workload, we do not believe this possible gain would favorably affect the end result, and we doubt that many internists would be willing to accept all assignments.

Third, the effect of federal intervention in payment for medical care has stimulated a series of reactions and counter-reactions by all segments of the affected population—including patients, providers and third parties. Two notable effects have been the increased demands for services resulting from the program itself and public pressures to extend the benefits provided. Both effects led to increased program costs, which stimulated government reactions, which in turn have resulted in the original usual, customary and reasonable fee (UCR) quickly becoming a label more than a reality.

For example, the method for determining customary and prevailing charges has been modified several times. In January 1971 carriers were instructed to decrease the prevailing charge level from the 83rd percentile of customary charges to the 75th. In August 1971 an executive order froze fee levels. In November another executive order established base prices and limits on increasing charges. This was followed by regulatory orders basing the prevailing charge determinations on customary charges that can be as much as 30 months out of date. In 1975 the economic index limit formula, using surrogate indices to represent physicians' costs and earning levels, was applied. The initial effect of the economic index limit, although later corrected, was not just to limit program reimbursement, but to roll back reimbursement in some cases. Each of these reactions has contributed to a widening disparity between program reimbursement and physician charges. Is it any wonder that increasing numbers of physicians reacted defensively and have increasingly elected to abandon the acceptance of assignments?

Given this situation and the ever-present belief that similar government reactions are likely in the future, we believe most internists would choose not to participate if there were an all-or-none assignment option. Most would prefer to maintain the individual patient assignment option. This would permit a limited continuation of the medical tradition of seeking reimbursement according to the patient's ability to pay, and allow the physician an opportunity to assist poorer patients by accepting assignments.

Last, it should be recounted that, when the Medicare issue was considered initially by the House of Representatives, opposition was expressed by some segments of the medical profession to the enactment of such a measure. It was asserted that such laws rarely achieve their stated goals within the original cost estimates, and subsequent pressures to control the unexpected costs stimulate legislative amendments and bureaucratic regulations that create new problems and impose additional regulatory barriers to efficient function. The events since 1965 have proven this to be an accurate assessment.

Ways and Means Committee Chairman Wilbur Mills attempted to convince his colleagues of the wisdom of the proposal and to allay concerns of the medical profession. At that time he stated:

"Now what is it (that has) . . . so greatly disturbed this great, wonderful medical profession . . .? Is it that we would finally, in time, put physicians' fees under a system where there would be payroll tax, because they felt that if we ever did that, we would in time regulate the relationship between the physician and the patient by saying that this physician you can go to and this physician is not on our list; or by saying that we will pay of this fund only this amount in the way of physicians' fees and thus control and regulate physicians' fees . . . We are not going to deal with the physicians direct; there is no intention to tell them what they may charge their patient; and we are not going to say to a patient, 'You have got to go to Dr. X; you cannot go to Dr. Y' . . . But we even go this extent because we recognize the sensitiveness on this issue: we say, 'We will leave to the election of the doctors, whether they are paid directly by the insurer, or whether the insurer pays the amount to the patient and the patient then pays the doctor.' "

Such persuasion eventually convinced members of the House that the Title XVIII program would not adversely affect the active participation of the medical profession in providing the benefits granted by Congress. Now, 11 years later, Congress is again addressing these issues, including specifically the assignment option under the Medicare program. It is the view of ASIM that elimination of this individual patient assignment option would constitute bad faith on the part of government in light of the original intent of the Medicare law. Such an action will seriously alienate many of those professional organizations and individual physicians who have attempted to cooperate with government in seeking satisfactory implementation of this law.

A critical factor in acceptance of assignment is the attitude of each physician toward the program. It is easy to perceive that the general attitude of physicians has deteriorated. The promised UCR reimbursement has not been provided because of the progressive distortion of the process of determining prevailing charge levels. Subsequent regulatory impositions have become so significant that it is wise for a physician not to accept assignment in order to avoid being in violation of the law or regulations inadvertently. In the long run the ASIM believes that patients and the credibility of government will become the ultimate losers if the all-or-none assignment option should be adopted.

REIMBURSEMENT FOR PRIMARY CARE SERVICES

As stated previously, health insurance plans, both public and private, traditionally have made reimbursement easier and more rewarding for procedural services (doing) than for medical judgments (thinking). ASIM believes that increased recognition of the value of medical judgments, which is a critical requisite of primary care, will better equate the economic incentives to deliver primary medical services with the real medical needs of the public. It has been argued that there are too many surgeons and too many hospital beds due to the availability of better insurance coverage for surgery and hospitalization. Improved insurance reimbursement for medical judgments will increase the availability of primary care services and tend to reduce the utilization of more expensive hospital services.

Better insurance coverage for procedural services resulted from the natural evolution of the health insurance concept and the difficulties in describing and reporting ambulatory medical services. The problem of describing these services has been essentially solved by *Current Procedural Terminology* (CPT), a coding and terminology system for all medical services and procedures which was developed by the medical profession. The insurance industry and the medical profession agree that a uniform coding and terminology system is needed. ASIM supports nationwide adoption of CPT. We believe this will allow physicians to describe their services accurately and that, with claims experience, third parties will be able to assure more accurate reporting by physicians and therefore more equitable reimbursement mechanisms can evolve.

In summary, we believe that nationwide adoption of CPT and greater recognition for medical judgments would upgrade the quality and increase the availability of primary care services.

NEGOTIATED FEE SCHEDULES

ASIM fears that what at first glance appears to be a simple idea—replacing current reimbursement mechanisms with annually negotiated fee schedules—will prove to be anything but simple. Few physicians are willing to transfer their negotiation rights to other parties, even other physicians or physician organizations. When such an approach was tried in the private sector (i.e., the Blue Shield experience) so many inequities resulted that most physicians lack confidence in a negotiated fee schedule. Although physicians cooperated in this effort in good faith, some were eventually victimized, not only by inequitable remuneration but also by being blamed unjustly for shortcomings of the program. No matter how reasonable and fair a negotiated fee schedule might be initially, past experience with government programs indicates that future distortion by legislative amendment and bureaucratic regulation is inevitable.

The medical profession is also disturbed by the fact that the Congress is even considering a fee schedule and an all-or-none assignment option, which would be a fee schedule for participating physicians. How can Congress consider fee schedules when another government agency, the Federal Trade Commission, is investigating charges that the medical profession has eliminated competition through standardization of fees? If fees have become standardized, it has not been due to any concerted effort by the profession. Quite the contrary—any standardization has largely been the result of insurance payments mechanisms, both public and private. Third party intervention in the physician-patient relationship has pressured physicians to accept reimbursement levels determined by the third party.

Therefore, we believe even a diluted UCR reimbursement method is preferable to a negotiated fee schedule.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE ON THE "MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT," S. 3205 PRESENTED TO THE SUBCOMMITTEE ON HEALTH, SENATE FINANCE COMMITTEE, AUGUST 1976

SECTION 2. ESTABLISHMENT OF HEALTH CARE FINANCING ADMINISTRATION

The American Society of Internal Medicine (ASIM) supports the establishment a Health Care Financing Administration as an interim step in reorganization of the administrative agencies for federal health programs. Such reorganization should result in greater administrative efficiency and better enable the public, physicians and the Congress to identify the accountable unit.

The major deficiency of this proposal is that responsibilities for financing and health services will still be divided. In the past many administrative decisions based on financial considerations have compromised the quality of health services. We strongly recommend that the bill be amended to specify that the Assistant Secretary for Health Care Financing be a physician. This should ensure that decisions due to financial considerations are not made in a vacuum without regard for quality.

ASIM believes the optimal administrative structure should be designed to consolidate all federal health programs to allow better coordination such as the establishment of a separate cabinet-level department of health.

SECTION 3. INSPECTOR GENERAL FOR HEALTH ADMINISTRATION

ASIM concurs that fraud and abuse must be eliminated from federal and other health programs. However, the authority proposed for the Inspector General seems dangerously broad and we suggest three minor modifications which should not restrict the ability of the Inspector General to carry out his assignments.

First, the apparent blanket access afforded to the Inspector General to all DHEW reports, audits, documents, etc., necessary to discharge his responsibilities should be modified to assure confidentiality and to require adherence to the confidentiality requirements of the affected federal programs.

Second, the subparagraph providing the Inspector General with $100,000 "bag money" should be deleted. It should not be necessary for the Inspector General to engage in clandestine activities.

Lastly, because one of the apparent purposes of the Inspector General and the Office of Central Fraud and Abuse is to control program costs, the Inspector

General should be required annually to report the cost effectiveness of his activities.

SECTION 7. REGULATIONS OF THE SECRETARY; SAVINGS PROVISIONS

ASIM supports this provision which would prevent a proposed rule or regulation from becoming effective in less than 60 days following publication in the *Federal Register* unless it states that prompt promulgation is urgent. However, any stated need for prompt promulgation should be supported by fact.

SECTION 8. TERMINATION OF THE HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

The stated reason for discontinuing the Health Insurance Benefits Advisory Council (HIBAC) is that it is no longer significant in policy development for Medicare and Medicaid. What has not been stated is that the reason HIBAC has not recently played a significant role is that it has been denied the opportunity to do so. Initially HIBAC served as a valuable advisory group. But as the programs evolved, bureaucratic policy direction appears to have replaced outside advisement. Non-governmental input into federal policy making is an integral part of our democratic process and we strongly recommend that HIBAC be continued and assigned a meaningful advisory function.

SECTION 20. CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS SERVICES

Because much of this section is a restatement of existing legislation governing the determination of prevailing charge levels, we believe it is appropriate to again express ASIM's opposition to the inadequate reimbursement to patients for physicians' services. The intent of the original Medicare legislation was to reimburse beneficiaries based on the usual, customary and reasonable (UCR) concept. Subsequent amendments and regulations eroded and distorted the original UCR concept and have caused a widening disparity between program reimbursement and physician charges. This accounts for most of the increased out-of-pocket expenditures by beneficiaries and the declining rate of assignment acceptance by physicians.

Imposition of the state-wide prevailing charge levels called for in this section may further increase this disparity. While ASIM concurs with the goal of attracting more physicians into rural areas, it does not believe restricting reimbursement differentials between patients of urban and rural physicians in this manner will accomplish the intended goal. A more obvious effect is likely to be a curtailment of patient reimbursement for the services of urban physicians rather than a positive economic incentive for rural physicians. ASIM recommends that this provision be deleted or at least amended to include authorization for exceptions in instances where large differentials appear warranted because of high overhead expenses in urban areas.

SECTION 21. AGREEMENT OF PHYSICIANS TO ACCEPT ASSIGNMENT OF CLAIMS

ASIM strongly supports the retention of the individual patient assignment option

We are *adamantly opposed* to the creation of two classes of physicians under Medicare—"participating physicians" (those agreeing to accept assinmgent on all Medicare patients) and "non-participating physicians" (those not permitted to accept assignment on any Medicare patients).

It has been a tradition of medicine to treat patients individually, and to seek reimbursement according to their ability to pay. The individual patient assignment option has allowed continuation of this tradition for Medicare patients. Because of the increasing disparity between program reimbursement and the actual charges, the marjority of primary care physicians would be forced to assume a non-participating status, thereby denying them the opportunity of assisting poorer patients by accepting assignments. This would make access to care more difficult for poorer patients.

The proposed provision would allow participating physicians to bill on a multiple-listing basis, would pay 50% of those bills within five days and would provide a $1-per-patient "administrative cost-saving allowance." ASIM believes these would not be sufficient incentives to override concern with low program reimbursement or to induce physicians to forfeit their freedom to bill directly. While the ideas of multiple-listing billing and more rapid payment are commendable, they should be accomplished without requiring physicians to accept assignment on all patients. The $1 cost-savings allowance is arbitrary and its effect would vary from physician to physician. For example, physicians who see fewer patients will find the $1 less of an incentive. And, for physicians providing more comprehensive services, this amount is insignificant when compared with the differential in reimbursement between accepting and not accepting assignment. What adoption of this provision will probably do is encourage low quality, frequent return type practices specializing in Medicare patients in order to capitalize on the $1-per-patient incentive. Although a very small minority of physicians are likely to be involved in such practices, the result could be inferior care to a significant number of Medicare patients.

SECTION 22. HOSPITAL-ASSOCIATED PHYSICIANS

This section, although titled "Hospital-Associated Physicians" would establish a new legislative criteria for defining all reimbursable physician services under the Medicare program. The new definition of "physician services" would exclude services performed as an educator, an executive or a researcher, and would exclude any patient care services unless such service was (1) personally performed or personally directed by a physician for the benefit of such patient and (2) is of such a nature that the performance by a physician is customary and appropriate.

ASIM objects to this definition of what constitutes physician services. Physicians should be reimbursed under Medicare for services which are recognized as appropriate medical practice within their state. The proposed definition is vague and could be subjected to varying regulatory interpretation. Because of its vagueness, it could be interpreted in ways that would further limit services reimbursable under Medicare.

SECTION 25. PAYMENT UNDER MEDICARE OF CERTAIN PHYSICIANS' FEES ON ACCOUNT OF SERVICES FURNISHED TO A DECEASED INDIVIDUAL

ASIM supports this provision to provide greater flexibility for survivors of deceased beneficiaries in obtaining payment for services rendered to the beneficiary.

SECTION 26. PROHIBITION AGAINST ASSIGNMENT BY PHYSICIANS AND OTHERS

This section would limit the circumstances under which payment for services could be assigned to a third party (agent). Such assignments could only occur pursuant to an agreement with an agent under which the compensation to be paid to the agent was not dependent either upon the amount of billing in payment, or upon the actual collection of any such payment. ASIM recommends that this section be deleted since it interferes with the contractual rights of individuals.

SECTION 33. VISITS AWAY FROM INSTITUTIONS BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

This section allows a Medicare patient in a skilled nursing facility or in an intermediate care facility to make visits outside the institution without such visits being conclusively regarded as indicating that the patient is not in need of the facility's services. This is highly commendable. If more regulations which affect patient care were similarly flexible to allow application on an individual patient basis, physicians would find federal health programs much less objectionable.

SECTION 42. AMBULANCE SERVICE

This section extends Medicare coverage to provide ambulance service to the nearest hospital only if it is adequately equipped and staffed to provide the necessary treatment. This addresses only part of the identified problem. While it fills the obvious need for adequate facilities, it ignores the desirability of having the patient treated by his personal physician. The proposed wording of this section perpetuates this problem in many cases. It is recognized that there are instances which preclude taking a patient to the hospital where his physician has privileges (i.e. when there is an unreasonable distance to travel or when there is an emergency requiring prompt treatment). However, it is often unreasonable to deny a patient treatment by his personal physician in the absence of such conditions. When treatment is provided by another physician unnecessary repetition of tests and longer hospital stays often result adversely affecting the cost of medical care.

HUNTERSVILLE, N.C.,
August 5, 1976.

DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, Committee on Ways and Means, Longworth House Office Building, Washington, D.C.

DEAR SIR: This is in response to your announcement of a hearing on the Medicare physician reimbursement system. I am a young, board certified Family physician practicing in a rural community just twenty minutes outside of a large city, Charlotte, North Carolina.

In regards to item (4) on your list dealing with "reasonable charges between urban and rural" physicians, I feel that there should not be any difference due to geographical location. As a matter of fact, the rural primary care physician often has to make far more intricate evaluations during an office visit, as his patient may rarely come to the doctor and this brief visit may have to serve this particular patient for months or even years.

In regards to item (5) relating to "differentials between primary care physicians and other physicians", I can only speak for myself as a family doctor. I feel that an honest evaluation of the patient's problem should be compensated at my usual and customary fee. This takes into account all the factors that affect my particular practice. I do not compete with the subspecialists and their fee schedule, but do feel that I should not be penalized by other primary care physicians who may have a lower fee schedule than mine and who may practice a different brand of medicine than I.

In closing, item (6) deals with a set fee schedule. This of course would be simple and effective if you could get the Harvard professor, New York surgeon and Plains, Georgia family doctor to agree on "customary and prevailing charges".

Yours truly,

CHARLES T. ELLITHORPE, M.D.,
North Mecklenburg Family Practice Group, P.A.

STATEMENT OF PETER FISHER, SANTA BARBARA, CALIF.

It is my observation that the *amount* of fees payable to physicians on behalf of Medicare patients is of little or no concern to the overwhelming majority of physicians. Rather, their greatest concern, and the reason for the reluctance of most physicians to accept assignment of Medicare reimbursement, is the *time*, *effort* and *cost* now required to claim and collect whatever fees are payable.

The cheapest, most practical and most acceptable solution to this problem is simply to adopt the same kind of fee-scheduling, claim form, mode of payment, utilization review and budgeting method used with such outstanding success by the province of British Columbia, Canada, Medical Services Insurance Plan for the past eight years. This system has been modified to meet our requirements in the United States and incorporated in H.R. 3252, the National Voluntary Medical and Hospital Services Insurance Act introduced by Mr. Ketchum and Mr. Lagomarsino.

The actual performance of this system, if adopted by Medicare, can be accurately predicted by reference to the recently completed Lewin & Associates study for D.H.E.W. of the Canadian experience with government controls on the health care system under the ten provincial health insurance plans. A detailed tabulation and summary of the fiscal and operating experience of the British Columbia Medical Plan for the past five years, which I have prepared, is attached hereto together with a reproduction of the physician's claim form.

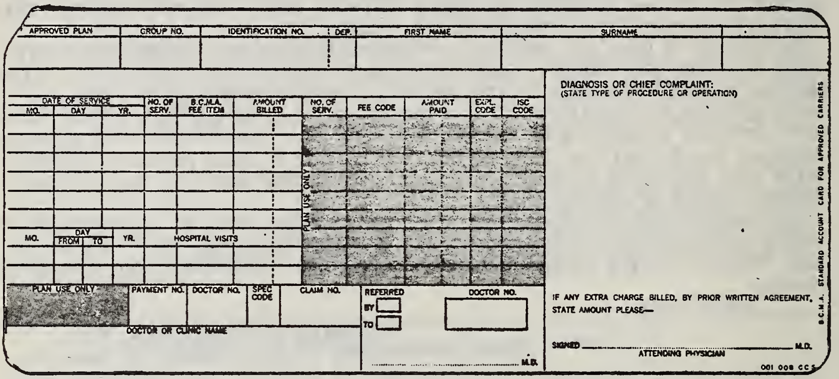
My proposal can be briefly described as follows:

1. A code-numbered schedule to be prepared listing every medically recognized mental and physical disorder or disease, symptom or syndrome, and related diagnostic and therapeutic procedures.
2. A standard fee to be assigned to each listed procedure, through consultation with the medical professional association in each state.
3. An across-the-board or variable percentage of each standard fee to be payable on behalf of Medicare patients in each state to be determined by Medicare managers in consultation and negotiation with each state medical professional association annually and with respect to available funds and utilization trends.

4. All claims to be submitted by participating physicians on short-form, keypunch computer entry cards, to be subjected only to clerical audit and payable in a single consolidated payment to each physician within 45 days of month submitted.

5. Total cumulative claims by each physician to be computer generated and reviewed periodically in relation to the composite profile of all claims by all physicians in similar practice in the same area and nationally. Sanctions to be applied against physicians found to be billing fraudulently, excessively or without medical validity.

Reproduction of physician claim form used by British Columbia Medical Services Insurance Plan



APPROVED PLAN | GROUP NO. | IDENTIFICATION NO. | DEP. | FIRST NAME | SURNAME

DATE OF SERVICE			NO. OF SERV.	B.C.M.A. FEE ITEM	AMOUNT BILLED	NO. OF SERV.	FEE CODE	AMOUNT PAID	EXPL. CODE	ISC CODE
MO.	DAY	YR.								

PLAN USE ONLY

MO. | DAY FROM | TO | YR. | HOSPITAL VISITS

PLAN USE ONLY | PAYMENT NO. | DOCTOR NO. | SPEC CODE | CLAIM NO.

DOCTOR OR CLINIC NAME

REFERRED BY ☐ TO ☐ DOCTOR NO.

M.D.

DIAGNOSIS OR CHIEF COMPLAINT:
(STATE TYPE OF PROCEDURE OR OPERATION)

IF ANY EXTRA CHARGE BILLED, BY PRIOR WRITTEN AGREEMENT, STATE AMOUNT PLEASE—

SIGNED ______________________ M.D.
ATTENDING PHYSICIAN

B.C.M.A. STANDARD ACCOUNT CARD FOR APPROVED CARRIERS

001 008 CCS

British Columbia Medical and Hospital Services Insurance Plans

OPERATING AND FISCAL EXPERIENCE FOR SIX YEARS: 1969/70 THROUGH 1974/75

(Prepared by Peter Fisher, Santa Barbara, 1621 State St. 93101. Sources: B.C. Hospital Insurance Service & Medical Insurance Commission annual reports and B.C. Medical Association)

The British Columbia Hospital Insurance Service was introduced in 1949 and pays for total acute & extended care; emergency; out-patient; day-surgery; renal dialysis; cancer, diabetic, psychiatric & drug addiction diagnosis and therapy; for all residents who pay only $1 a day in-patient charge and $2 a visit out-patient charge. The service also provides construction & operating advice and building grants for community-owned hospitals and controls hospital expansion on a regional basis to avoid duplication of facilities and waste. Also pays emergency hospitalization for residents travelling abroad.

Medical Insurance Plan was introduced in 1968 and is separate to hospital plan. Enrollment is *voluntary* with monthly premiums ranging from 50¢ ($1.25/family) to a maximum of $5 ($12.50/family) depending on income. Plan pays for total necessary medical care, in and out of hospital, without limits, exclusions, deductibles or copayments. The independent fee-for-service private medical profession is solely responsible for controlling costs and utilization of benefits by physicians and their patients through periodic review of each doctor's total billings and profile of practice over a period of time rather than on a claim-by-claim basis; this system eliminates more than 90% of paperwork and administrative costs required by typical U.S. public and private insurance plans.

Both plans receive approximately 35% to 40% of their total funds from capitation grants by the Government of Canada. The other nine provinces of Canada also have medical and hospital insurance plans, all somewhat different to each other but all qualifying for federal financial assistance. Only the B.C. medical plan has entirely voluntary enrollment and both the B.C. medical and hospital plans appear to show substantially lower utilization rates and cost inflation during recent years than ony of the other provincial plans despite a large influx of doctors to B.C.

		1970	1971	1972	1973	1974	1975
	B.C. MEDICAL INSURANCE PLAN						
1	Total enrollments during year (estimated 98 percent of population)	1,920,000	2,085,000	2,260,000	2,325,000	2,430,000	2,550,000
2	Average monthly premium (50¢ to $5 depending on income)	$2.95	$2.94	$2.86	$2.92	$2.92	$2.91
3	Average annual premium per enrollee	$35.40	$35.32	$34.34	$35.00	$35.00	$35.00
4	Total annual premium income (actual)	$67,904,845	$73,650,125	$77,623,001	$81,382,550	$84,989,930	$89,209,995
5	Government of Canada (50 percent national average medical costs)	$36,116,023	$51,935,037	$60,024,329	$64,710,196	$70,966,637	$91,405,097
5a	Item 5 expressed as per capita subsidy (line 5 divided by line 1)	($18.81)	($24.90)	($26.55)	($27.83)	($29.09)	($35.84)
6	Government of British Columbia (general fund subsidies)	$17,306,825	$16,916,310	$17,410,680	$18,215,574	$19,279,047	$20,720,138
6a	Item 6 expressed as per capita subsidy (line 6 divided by line 1)	($9.01)	($8.11)	($7.70)	($7.83)	($7.93)	($8.12)
7	Miscellaneous income & investment interest	$1,729,674	$2,164,401	$1,999,293	$3,160,621	$3,977,684	$5,323,636
8	Total income from all sources (lines 4 plus 5 plus 6 plus 7)	$123,057,367	$144,665,873	$156,605,894	$166,876,394	$178,517,650	$206,658,866
9	Average gross income per enrollee (line 8 divided by line 1)	$64.09	$69.38	$69.29	$71.77	$73.46	$81.04
10	Total payments for medical service benefits	$106,942,396	$121,865,445	$132,453,901	$142,800,225	$162,757,882	$200,852,158
11	Average medical service payments per enrollee (10 divided by 1)	$55.69	$58.44	$58.61	$61.42	$66.97	$78.76
12	Total medical service units (claims) paid by plan	14,500,000	15,143,000	16,140,000	17,500,000	18,540,000	21,000,000
13	Average claims per enrollee (utilization—line 12 divided by 1)	7.5	7.3	7.1	7.5	7.6	[2] 8.2
14	Average cost per claim or medical unit (line 10 divided by 12)	$7.37	$8.05	$8.21	$8.16	$8.77	$9.56
15	Approximate number full-time fee-for-service M.D.'s in plan	2,350	2,600	2,850	2,950	3,160	3,400
16	Ratio of M.D.'s to enrollees in plan (line 1 divided by 15) (approximately 1,500 additional M.D.'s in salaried staff jobs)	1:817	1:800	1:790	1:788	1:769	1:750
17	Average claims per M.D. (line 12 divided by line 15)	6,170	5,824	5,663	5,932	5,867	6,176
18	Average gross fees paid to all M.D.'s (line 10 divided by line 15)	$45,500.00	$46,800.00	$46,500.00	$48,000.00	$51,500.00	$59.074.00
19	Nonmedical benefits paid (chiropractic, nursing, etc.)	$6,775,455	$6,324,859	$5,563,924	$7,743,680	$8,693,565	$11,114,830
20	Total administrative expenses of commission and plan	$5,687,035	$6,030,059	$6,567,847	$7,320,137	$8,581,794	[1] $12,501,015
21	Administrative expenses expressed as percentage of income (8 divided by 20)	4.6	4.1	4.1	4.3	4.8	7.5
22	Total administrative cost per claim paid (line 20 divided by 12)	$.39	$.40	$.41	$.42	$.46	[1] $.51
23	Cash operating surplus or (deficit—line 8 minus 10, 19, and 20)	$3,652,481	$10,445,510	$12,714,657	$6,103,752	($6,632,642)	($17,809,137)
24	Accumulated operating surplus	$1,122,750	$5,623,370	$18,338,027	$24,441,779	$17,809,137	0

See footnotes at end of table.

		1970	1971	1972	1973	1974	1975
	B.C. HOSPITAL INSURANCE SERVICE—Continued						
25	Approximate income from patient $1 per day and $2 per visit charges	$5, 200, 000	$5, 750, 000	$6, 500, 000	$8, 200, 000	$8, 400, 000	(3)
26	Approximate Federal capitation and Province general funds	$153, 700, 000	$179, 300, 000	$201, 600, 000	$228, 900, 000	$268, 900, 000	(3)
27	Actual receipts and expenditures (claims, grants and administration)	$158, 901, 010	$185, 068, 873	$208, 067, 349	$237, 133, 099	$277, 302, 574	(3)
28	Total per capita cost for residents (line 27 divided by line 1)	$82. 76	$88. 76	$92. 06	$101. 99	$114. 11	(3)
29	Total days of hospitalization in acute-care hospitals	3, 465, 504	3, 486, 671	3, 543, 587	3, 474, 733	3, 449, 166	(3)
30	Total number of patients hospitalized (acute care)	369, 210	379, 144	388, 747	392, 550	398, 529	(3)
31	Average length of stay in acute-care hospitals (days)	9. 4	9. 2	9. 1	8. 8	8. 6	(3)
32	Days in hospital per capita (line 29 divided by line 1)	1. 8	1. 7	1. 7	1. 5	1. 4	(3)
33	Total days of extended-care hospitalization	531, 808	672, 099	817, 321	1, 044, 529	1, 187, 000	(3)
34	Total number of patients hospitalized (extended care)	1, 022	1, 495	1, 822	2, 293	2, 475	(3)
35	Average length of stay in extended-care hospitals (days)	520	450	449	456	480	(3)
36	Total outpatient, emergency, day-surgery and clinic visists	235, 000	292, 850	453, 589	792, 367	985, 300	(3)
37	Outpatient, etc., visits per capita (line 36 divided by line 1)	. 12	. 14	. 20	. 34	. 40	(3)
38	Total administrative cost (including construction planning)	$1, 135, 918	$1, 261, 940	$1, 400, 095	$1, 538, 905	$1, 800, 230	(3)
39	Administrative cost as percentage of total budget (line 27 divided by 34)	. 71	. 68	. 67	. 64	. 64	(3)
40	Averaged administrative costs of combined medical and hospital plans as percent (lines 8 plus 27 divided by lines 20 plus 38)	2. 41	2. 21	2. 18	2. 19	2. 27	(3)

---

[1] 1974/75 administrative costs included a one-time expenditure of $2,108,471 for consolidation of all claims processing in a single computer center (from 3 locations); the change-over resulted in some delays in payments to doctors and some discrepancies in tabulating numbers of claims submitted (lines 12, 13, 14 and 17). It is estimated, however, that during the year medical service fee schedules increased an average of about 15 percent and utilization rates increased approximately 8 percent reflecting the official policy of the socialist NDP government of the day to encourage greater use of the health plan benefits by the residents of the Province.

[2] X-rays and laboratory tests account for 25 to 30 percent of total claims.

[3] Not available as of Jan. 31, 1976.

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

This is a statement on behalf of the Health Insurance Association of America representing a membership of 318 insurance companies which is responsible for approximately 85% of the health insurance policies written by insurance companies in the United States.

In particular, this statement represents the views of the member companies of the Association involved in the administration of Medicare. These companies are: Aetna Life & Casualty, Mutual of Omaha Insurance Company, Nationwide Mutual Insurance Company, The Prudential Insurance Company of America, The Travelers Insurance Company, Connecticut General Life Insurance Company, CNA/insurance, Equitable Life Assurance Society of the United States, General American Life Insurance Company, Metropolitan Life Insurance Company, Occidental Life Insurance Company of California, Pan-American Life Insurance Company and Union Mutual Life Insurance Company. All of these companies serve as carriers under Part B (Supplementary Medical Insurance). In addition, the first five companies named also serve as fiscal intermediaries for hispitals, home health agencies, and skilled nursing facilities under Medicare Part A (Hospital Insurance Benefit). We appreciate the opportunity to comment on the topics the Subcommittee has under consideration and will discuss them in the order listed in the announcement of the hearing.

1. The factors influencing physicians' decisions to accept or not accept assignment of Medicare claims are varied, but generally are economic considerations.

Probably the most important reason for not accepting assignments is the deterioration in the level of allowable benefit payments as compared with the level of physicians' charges. It must be remembered that the charges rendered to Medicare patients are merely a reflection of the physicians' charging practices for all patients. There is a widening gap between the Medicare allowances and the physicians' customary charges. A review of the history of Medicare benefit payment determinations illustrates the current problem.

In 1966, the Medicare law provided that benefits should be paid on the basis of reasonable charges. The determination of a reasonable charge involved consideration of the physician's usual charge for the service performed but payment could not be made for charges that exceeded the prevailing charge for a like service in a given geographic locality. This definition provided a great promise to beneficiaries for adequate reimbursement of medical expenses. Also, it provided an incentive for physicians to accept assignments since there was hope that in most cases the charges would be judged to be reasonable. Unfortunately, over the past 10 years, there has been an erosion of the level of benefits payable through more refined interpretations of the allowable prevailing charge. First by regulation, and later by law, the prevailing charge was defined to be the 75th percentile of all of the usual charges in a locality. During the period of the economic stabilization program, the Medicare benefit was determined to be a "price" and therefore subject to control. This further depressed the yearly update of prevailing charges by Medicare carriers.

Finally, on July 1, 1975, our yearly update of prevailing charges based on the prior year's calendar charges was subject to a new provision in the law providing that the newly calculated prevailing charges could not exceed an amount 17.9% higher than the prevailing charges during fiscal year 1973, which were based on actual charges rendered in 1971 at which time the economic stabilization program was in effect. This introduced another factor for the depression of the level of benefits allowable and widened the gap between the allowable Medicare benefit and the actual charges being rendered by physicians currently.

Because of all of the changes indicated above, physicians have become more and more reluctant to accept assignments in view of the proviso that the physician must accept the allowable charge under Medicare as a full charge.

Furthermore, the economics of operating a physician's office enters into the decision not to accept assignments because, in addition to the significant difference between Medicare benefit payments and customary charges, the physician eliminates much of the bookkeeping and collection expenses inherent in handling deductibles, coinsurance and the unknown amount of the difference between Medicare benefit and the actual charge. In the absence of assignment, the physician deals directly with the patient in the collection of the total charge, leaving to the Medicare patient the filing of the claim, and receipt of whatever benefit is available.

Obviously, an increase in the assignment rate can be achieved only through economic incentives to the physician which will overcome the disadvantages to the physician described above. Certainly, relief to the physician in the area of bookkeeping and collection problems would provide some incentive, but, the principal economic problem lies in the widening difference between Medicare benefits and physicians' charges. If the Medicare payment is not reasonably close to the customary charge made to all patients, there cannot be much hope for increasing the assignment rate.

One alternative might be to provide that the reasonable charge determination would be based on a percentile of usual charges higher than the 75th percentile. On the other hand, this approach could increase significantly the cost to the Federal Government for Medcare benefits and it is evident that the current level of cost to the government is of serious concern to the Congress.

2. Requiring physicians to accept assignment on all Medicare claims as a condition for receiving reimbursement for any claim on assignment basis could be counterproductive. Such an approach undoubtedly will result in decisions by many physicians, who sometime accept assignments currently, not to accept any assignments. Presently, many physicians are selective in their decision to accept assignments, reflecting their awareness of the adequacy of patients' resources. In other words, assignments are accepted only when the physician is aware that the patients' financial resources are rather limited. In other cases, physicians will accept an assignment if large amounts are involved, such as charges for major surgery, but, because of the recordkeeping involved, do not take assignments where the charges are relatively low.

The all-or-nothing approach to assignments probably would result in an overall assignment rate much lower than the present rate. The mandatory approach does have the advantage that Medicare beneficiaries can be informed in advance as to whether a particular physician will or will not accept an assignment. With this information, the patient knows whether to expect billing for amounts in excess of Medicare benefits.

3. & 4. Geographic variations in Medicare reasonable charges reflect variations that exist for all patients, and, once again, the reasons for such variations are economic in nature. Differences throughout the United States and differences within a given state between urban and rural areas generally reflect the varying economics of medical practice from one area to another.

First, it must be recognized that there are variations throughout the country, and certainly between urban and rural areas, in the expense of operating a medical practice. Generally, in the more rural areas, office rent and clerical salaries are lower than in urban areas. The clerical turnover in a physician's office generally is lower in the more rural areas than in the cities, and this is related to the difference in salary competition and the availability of jobs between the rural and urban areas. Malpractice insurance premiums tend to be higher in the urban areas and vary considerably from state to state. Furthermore, a physician must establish his charges for all patients in consideration of the income levels of the population he serves, and, again, the per capita income tends to be lower in the more rural areas. All of the above constitutes the rationale for variation of physicians' charges by area, and it must be emphasized again that Medicare benefits are related to actual charges by physicians made to the entire patient population, not just to Medicare patients.

Again, since Medicare beneficiaries constitute only a minor part of the total population, efforts to attract physicians to rural areas to alleviate shortages of physicians through increases in the Medicare payments to such physicians could have only a minimal effect on location decisions. Such decisions are influenced by many factors other than the level of third party reimbursement including the availability of hospital affiliations, contacts with their peers, life-style preferences, educational systems, and cultural attractions.

5. Medicare reasonable charge differentials do exist among the various categories of medical practice. There are differences depending upon a physician's specialty or lack thereof, but this, once again, reflects the charging practices of these physicians. Beyond the normal considerations of personal interest and skill in a field, monetary factors do exert a strong influence in the selections of a physician specialty, although Medicare reimbursement, except in rare cases, is not the dominant monetary factor. The day-to-day pressures of a nonspecialist general practice, with long and irregular hours, arouse diminishing interest on the part of newly graduating physicians. While monetary rewards do exist in a general prac-

tice, greater control over patients and regularity of hours and higher incomes exist in the specialty fields.

It is true there are still "crisis" conditions even for a specialist which can introduce unusual hours, but even these are frequently shared with other members of his specialty group as opposed to the solo general practitioner. The basic premise which accepts higher educational achievements and training as adding to a physician's qualifications and therefore permitting him to charge more for his services is difficult to change. The establishment of specialists in Family Practice in general medicine follows this pattern and in some instances has produced Family Practice partnerships where the burdens of practice are shared. If experience proves that the monetary rewards of a Family Practice specialty are as great as those of Internal Medicine or Orthopedics, etc., then the retention or return of physicians to the field of general medicine should eventually improve. To debase the rewards for specialists' services or upgrade reimbursement for general practice services would do little to change the long recognized specialty distinction. Specialists would withdraw from the Medicare assignment process or further inflate their prices to maintain their accepted "distance" above the general practice base.

6. Medicare reimbursement based on fee schedules offers some advantages over the existing system of benefit payments based on customary and prevailing charges. Both the patient and physician would know in advance the amount of Medicare reimbursement to be expected. Also, the use of fee schedules could produce some savings in administrative costs, but these costs represent a very small part of the total cost to the government for Medicare. On the other hand, consideration of the use of fee schedules presents many new problems.

If fee schedules are to be adopted, who will negotiate such schedules? Should the State Medical Societies negotiate statewide schedules for all physicians regardless of the differing economics of medical practice from area to area within the state, and without regard to specialty status? Or, would different schedules be negotiated by economic areas with differing schedules by specialty status? How will revisions and updates be handled?

If one of the goals in the decision to use fee schedules is to increase the assignment rate, certainly the initial schedules would have to reflect higher charges than those under the present system and this would, at least, result immediately in a significant increase in Medicare costs. Even if a statewide schedule is higher than the average of existing Medicare prevailing charges, it could well be too low for acceptance by physicians in urban areas, although more than adequate in rural areas, resulting in a decrease of the assignment rate in urban areas. A similar situation would prevail between specialists and nonspecialists with the use of an overall average fee schedule.

Although there are advantages to the use of fee schedules for Medicare reimbursement, so many new problems arise in connection with the determination of the appropriate schedules to use that it would seem desirable to review various approaches before adopting fee schedules as the sole basis for physician reimbursement under Medicare. We, therefore, recommend experimentation in the use of fee schedules to test alternative approaches which might lead to the solution of these problems.

7. Relative value scales measure only the relative difficulty of the coded procedures and determination of the appropriate factors for conversion of relative value schedules to fee schedules is related to the problems mentioned above. In the absence of the use of relative value scales, negotiation of fee schedules could produce many inequitable relationships among the various types of services included in the fee schedule.

It is recommended that in any experiments with fee schedule reimbursement for Medicare, serious consideration be given to the use of a national relative value scale with negotiations limited to the conversion factor which might be varied by areas, specialty, or other pertinent factors.

8. Although the 1972 Social Security Amendments provide for experimental programs within the Medicare system, we are not aware of any experiments which would be pertinent to the discussion of the items above.

9. Current legislation to reform Medicare physician reimbursement under consideration by the Congress include H.R. 6699, H.R. 13080 and its Senate counterpart, S. 3205.

It appears that the implementation of H.R. 6699 would result in a single fee schedule for each state which would reflect the average prevailing charges for Medicare and Medicaid throughout that state. This would be the result of the limitation that the cost to the Federal Government under such fee schedule may not exceed current payments under Titles XVIII and XIX. Since the Medicaid reimbursement for physician services generally is much lower than the Medicare reimbursement, the resulting fee schedule would have an adverse effect on Medicare beneficiaries and physicians with a significant decrease in the assignment rate and an increase in the out-of-pocket expenses encountered by Medicare beneficiaries.

With respect to H.R. 13080 and S. 3205, we agree with the provision in Section 20 for the improvement of the reimbursement to physicians in physician-shortage areas, but we do have some concern about other provisions of this section.

The application of a new limit on locality prevailing charges based on statewide prevailing charges, that is in addition to but separate from, the limit established by the economic index factor may further discourage the acceptance of assignments by physicians. We do not have a statistical evaluation of the impact of this proposal as set forth in this section of the bill, but believe that the two factors should be combined into an index factor that reasonably reflects the physician's cost of doing business in each major locality. While it is understandable that the Federal Government wishes to control increases in benefit payments, the impact on beneficiaries must be considered. If the proposed approach does, in fact, further limit annual increases in prevailing charges, with further decreases in the assignment rates, the elderly beneficiary will be hit even harder than he now is for out-of-pocket expenses. Because of the unknown degree of impact, this proposal should be deferred until all alternative methods of determining prevailing fees under Medicare have been investigated and tested. This should permit the ultimate implementation to be the best possible solution from the beneficiary's standpoint.

We do recommend that existing law be changed now to provide for the updating of physician profiles and prevailing charges on a semi-annual basis. The current system of annual updating on July 1 of each year based on charges rendered during the prior calendar year produces an excessive time lag. This is a disincentive to the physician in his consideration of whether to accept assignment of benefits.

Under the provisions of Section 21, the concept of "participating" and "nonparticipating" physicians seems logical on the surface. However, the implementation of this concept as specifically provided in the bill could be counterproductive. The all-or-nothing approach to assignments, combined with tighter controls and probably lower prevailing charge levels, will drive the assignment rate down because the "incentives" in this section are not sufficient to achieve a high rate of participation. In our view, the proposed billing and payment procedure would be a disincentive which would not be overcome by the $1 per patient "incentive."

The proposed simplified billing form could be an administrative monstrosity if all other requirements under existing rules and regulations must be met. Also, the partial payment to the physician within five days followed later with the many individual patient adjustments with respect to the deductible, reasonable charge, utilization, and eligibility determinations will create more record-keeping problems for the physician's office assistant. We recommend deletion of this provision.

An alternative approach which might have more appeal to the physicians would be to provide that reasonable charge determinations for participating physicians be based on a percentile higher than the 75th percentile, say the 85th. Physicians should be required to declare in writing to the carrier that they will either take assignments for all their Medicare patients or none of them. A physician could change his decision on sixty days' notice to the carrier. To improve administrative procedures and reduce expenses, it might be required that participating physicians code all claims.

We recognize the problems of the Federal Government in financing the Medicare Program. On the other hand, we also recognize the financial problems of the Medicare beneficiary and we hope that appropriate incentives can be found to increase the rate of assignments. Before *any* major changes are undertaken in a program as large as Medicare, we recommend experimentation to test alternative proposals before legislating changes which could have significant impact on costs and be extremely difficult to modify if expected results are not achieved.

We commend the Subcommittee on its interest and its efforts to meet some of the very difficult problems affecting the cost of the Medicare program and we offer the Subcommittee and its staff the continued cooperation of the Health Insurance Association of America in working out the solutions to these problems.

NORTH MECKLENBURG FAMILY PRACTICE GROUP,
Huntersville, N.C., August 10, 1976.

Hon. DAN ROSTENKOWSKI,
Subcommittee on Health, Committee on Ways and Means, Longworth House Office Building, Washington, D.C.

SIR: The following is a written response relating to revisions of the medicare Physicians Reimbursement System. The responses are designed to deal with specific questions to be presented at the hearing to be held August 25, 1976.

Question No. 1. Factors in the present medicare reimbursement system which influence physicians' decisions to accept or not accept assignment of claims and any changes which might encourage acceptance of assignment. (Physicians who agree to accept assignment, agree to accept the medicare reasonable charge as payment in full. For an assigned claim, a physician receives payment directly from the medicare program.

In the first place there should be a definition of reasonable charge established. It has been our experience that payment is usually a little more than 50 percent for routine visits and even less for laboratory tests. Since our overhead runs between 60–70 percent, we actually lose money everytime we see a medicare patient. We are left with three choices:

A. See the Medicare patient and accept the loss.

B. No longer accept Medicare patients.

C. Compromise our medical judgment and give these patients inferior care and less time, thus cutting the individual overhead.

"Reasonable" payment must take into account the quality of care the patient is given and must keep up with current inflationary trends.

Needless to say the amount of paperwork involved is also a deterrant to Medicare acceptance.

If PRSO is accepted on an out-patient basis, the need for more extensive record keeping will undoubtedly lead to increased cost and more Medicare denials.

Question No. 2. Consideration for and against changing present law (under which physicians may choose which claims, if any, they will accept on an assignment basis) to require physicians to accept assignment in all cases as a condition for receiving reimbursement in any case on an assignment basis.

The right to choose whether to accept or not accept assignment is one of the bright spots in the Medicare program and should be left as is.

Question No. 3. Factors contributing to geographic variations in medicare reasonable charges; the rationality of these geographic variations.

It would be nice if reasonable charge could be standardized or a nation-wide basis but charges do vary from place to place and this must be taken into consideration.

Question No. 4. Differentials in medicare reasonable charges between urban and rural areas; implications for present efforts to alleviate shortage of physicians in rural areas.

Reasonable charges should be made—perhaps on a State wide basis so that the charges could be the same for both urban and rural doctors. I am a young rural doctor, a graduate of a family practice program, practicing modern medicine, yet my reasonable charge is based on what two 70 to 75 year old doctors charge. These doctors practice an entirely different brand of medicine with very little overhead. My reasonable charge should be based on similar doctors who are practicing a similar type of medicine, as in Charlotte, North Carolina only 10 minutes away, if you want to encourage more rural physicians, you must at least treat them equal to their urban colleagues.

Question No. 5. Implications of medicare reasonable charge differentials between primary care physicians and other physicians, and between the various physician specialties, including implications for the supply of physicians choosing to practice in various fields.

If there is a shortage of primary care physicians giving medicare coverage, a major reason may be that reasonable charges are too stringent.

Question No. 6. The feasibility and desirability of reimbursement based on fee schedules rather than customary and prevailing charges; the relative roles of government, physicians and others in establishing schedules; the need to adjust schedules for variation in physicians' cost of doing business, speciality status, etc.

It makes little difference who sets the fee schedules, if they prohibit the private physicians from making a profit, yet causing him to have a large work load, the problem of acceptance continues to exist. It might be well to let the physician have a voice in the fee schedules as he will be more knowledgeable about relative costs. The physicians' involvement will encourage him to become a part of the system rather than we who are manipulated by a political scheme.

Questions No. 7, 8, 9. The role of relative value scales in determining physician reimbursement either under the existing medicare reasonable charge system or another system.

Results of experience or on going reimbursement programs which are possible alternatives to or improvements in the present medicare reasonable charge system.

Comments on legislation that has been introduced to reform medicare physician reimbursement, such as H.R. 6699 (Fulton), and S. 3205 (Talmadge) and its House counterpart H.R. 13080 (Duncan of Tennessee).

Needless to say, Health Care is a large industry. It makes little difference if the current system is changed, the end result is going to cost untold amounts of money, as always the real cost is always much more than thhe predicted. It would be wise for the Federal Government not to assume the role of provider and get out of the health care business as much as possible, and leave the industry to private enterprise. It is a fact that this country's greatness is based on private enterprise, competition and individual ingenuity. By giving handouts, the Federal Government is cutting into the heart of what has made this country so successful.

I represent the North Mecklenburg Family Practice Group-Private Clinic.

Sincerely,

JEROME HOWARD, M.D., *President.*

STATEMENT OF THE NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Let it be understood at the outset, the immediate aim of our Associations is the establishment of ceilings to contain the excessively rising costs of all significant health care items. The failure to do this in a manner that is both comprehensive and effective will mean that: (1) the present, highly inflationary trends in the health sector of the economy will continue; (2) the cost of health care will consume an ever-increasing proportion of our gross national product; (3) the proportion of the federal budget allocated to health care programs will continue to grow and crowd out other competing priorities; (4) the financial viability of the Medicare programs will be seriously impaired; and (5) increasing numbers of the elderly, even with Medicare protection, will be priced out of the health care market and denied access to needed care.

Although health care has become excessively institutionalized via hospitals, medical associates, health maintenance organizations, health centers, skilled nursing homes, etc., the physician's fee remains a key cost item and one deserving of attention by this Subcommittee as it considers changing Medicare's reimbursement policies.

There seems to be little dispute that with the introduction of Medicare and Medicaid in 1966, price increases in the health sector of the economy began to outpace price increases in other sectors. The only possible exception to this pattern occurred during the economic stabilization period (8/71 thru 4/74). What happened in the health sector while the program was in effect is still not clear. There is some agreement that the economic controls served to restrain wage demands in the labor-intensive health sector. Nevertheless, new studies of the control period find that the economic stabilization program (ESP) failed to slow down the rate of price increases in this sector (vs. general price increases) as much as official price indicators claimed. We therefore believe that it is safe to say that for a decade the rate of price increase for medical care services exceeded the general inflation rate during the non-ESP periods and approximated that general rate during the ESP period. The cumulative effect has been to lift the incomes of physicians and the costs of hospital rooms to dizzying heights.

The following table sets forth the annual rates of price increases in the medical care sector over the period 7/59 thru 12/75.

TABLE I.—ANNUAL RATES OF PRICE INCREASES

[In percent]

	Premedicare July 1959 to June 1966	Post medicare June 1966 to June 1971	Controls August 1971 to April 1974	1974 post controls April 1974 to December 1974	1975 December 1974 to December 1975
CPI, all services less medical care	2.0	5.8	5.2	9.5	7.7
CPI, medical care services	3.2	7.9	4.9	12.1	10.3
Hospital service charges	NA	NA	4.6	14.6	13.0
(Semiprivate-room charge)	6.0	14.8	5.7	16.9	14.7
Physicians' fees	2.9	6.9	4.0	12.8	11.8
Dentists' fees	2.3	5.9	4.2	9.6	7.8
Drug and prescriptions	—.7	1.0	.7	7.8	7.4

Source: U.S. Department of Labor, Bureau of Labor Statistics.

In the pre-Medicare period (7/59 thru 6/66), the annual rate of increase in the Consumer Price Index for all services (less medical services) was 2 percent, compared with a rate for physicians' fees of 2.9 percent. The rate for dentists was 2.3 percent. In the post-Medicare period (6/66 thru 6/71), dentists' fee rose at a 5.9 percent annual rate, approximating that recorded by the CPI for all services (less medical). However, physicians' fees increased at a 6.9 percent annual rate, significantly above the general rate of 5.8 percent.

During the economic stabilization period, it seems likely that the rates of increases were nearer to the general rate for services (5.2 percent) rather than the rates stated in the table (4.0 percent for physicians and 4.2 percent for dentists).

The post-control period (4/74 thru 12/74) has been called the "catch-up period" for the hospitals and physicians. The all services component (less medical services) of the CPI rose at an annual rate of 9.5 percent, while physicians' fees rose by 12.8 percent.

During 1975, physicians' fees again showed a strong leading pattern (11.8 percent vs. 7.7 percent). In March of 1976, the 8.8 percent rate of increase in physicians' fees was still exceeding the general 5.9 percent rate for services.

The tendency for the annual rate of increase in physicians' fees to exceed the general rate for services (less medical services) began about 15 years ago. This development corresponded with the rising popularity of medical insurance as an employer fringe benefit, and the great growth of third-party payments under Medicare and Medicaid. But prior to that time, an opposite trend had prevailed. As the following table shows, physicians' fees over the period 1940–1960, dropped 6 percent, whereas the CPI for all items rose 11 percent and for all services (excluding rent) rose 30 percent. Medical care rose 15 percent over the same period.

TABLE II.—*Consumer Price Index, BLS, rise percent, 1940 to middle of 1960, various items*

	Percent
All items (BLS)	111
All services (excluding rent)	130
Medical care	115
All physicians	94
General practitioners	97
Office visit	94
House visit	89
Obstetrical care	142
Surgeons	75

Source: "The Economics of American Medicines," Seymour E. Harris, p. 123.

It is most interesting that during this early period, an oversupply of specialists resulted in a decline in their fees vs. those of general practitioners. Surgeons' fees declined 25 percent, whereas those of general practitioners remained almost stable (at an index of 97 compared to 1940 prices).

Because physicians' fees and earnings have been inflating ever since 1960 at annual rates in excess of the general rates of inflation in the economy, attempts have been made to examine the productivity of physicians much as productivity is studied during wage negotiations in older established industries. Unfortunately, the reshlts of those studies have been inconclusive. The output of physicians cannot readily be quantified. They have been seeing an increasing number of patients by spending much less time on each patient than formerly and by forcing the patient to visit their offices. The lost time in movement between home or work and the physician's office is that of the patient (and so is the patient's waiting time in the office). There are unanswered questions as to whether or not the quality of work is as good during the present brief meetings between physician and patient as formerly (when the physician would examine and question the patient at greater length). Certainly, physicians claim they work longer hours than other professionals. But while there may be some substnace to the claim of growing productivity in their work, there is simply no hard data to substantiate the propriety of increasing physicians' fees and net income year after year at rates exceeding those of other professionals and providers of services.

Physicians either manage or are represented in the management of most elements in the health care industry. They are the leaders and as such, they have had great success in extracting more from the economy than other professionals. Moreover, they expect to perpetuate this trend.

It should not therefore be surprising that the health care industry has been leading the inflation bandwagon. The industry, as one of the nation's largest, bears a significant share of the responsibility for pushing along the nation's "hard core" price inflation; now running at about a 6 percent annual rate.

As mentioned hereinabove, in the 20-year period 1940–1960, fees for surgeons declined vs. the general CPI index as an oversupply of surgeons developed. It would seem that we could make a straight-forward inquiry into the economics of physicians' fees by examining demand and supply factors against price. The number of physicians per 100,000 of population is a simple annual figure expressing demand-supply factors. In 1965, there were 153 per 100,000 population. Five years later, this number had increased to 156 per 100,000. The increase came to a plateau in 1971 and 1972 at 174 per 100,000. In a continuing analysis over the years of fees-for-service, one would superficially expect fees to drop as the supply of physicians increased. However, quite the opposite trend has occurred. If one were looking at other sectors of the economy, one would try to seek explanations for this trend in administered prices, changes of productivity or some other convenient explanation. Unfortunately, there is no simple answer.

Certainly a more effective demand for physicians' services has developed. By this we mean that there are more people demanding physicians' services with the means of paying for those services (via third-party payment arrangements). We therefore believe that the effective demand for their services has been growing faster than the increase in the supply of those who are practicing. We have been losing physicians in increasing numbers to administration, a concommitant of institutionalizing health care, and to research, where the need for them has been multiplied by federal funding of research projects in many areas.

Federal health care programs have had many unexpected results. In the fields of aid (Medicaid), and insurance (Medicare), this federal support has enormously buttressed the third-party payment system started in the private sector.

There are at least two important consequences of the third-party payment system. First, health facilities covered under the third-party payment system tend to be overutilized, as compared to facilities not so covered. Second, payments via third-party arrangements are rarely scrutinized by the patient with the result that payments are not monitored at all or are monitored only partially by payment intermediaries or the government. Overcharges are rarely recaptured. Reverting to the economics of physicians' fees, the trend toward producing more specialists enjoying higher fees has been accelerated, apparently as an unexpected consequence of support of medical schools by federal and state governments.

Correction of the trend toward specialization is one of the objectives in the health manpower legislation still before the Congress. If such legislation is enacted, we would hope that it would reverse the past trend which has led to a great decline in the number of general practitioners. Some experts have argued that 85 percent of the health needs of the public can be met by general practitioners and that the decline in their number has become so great that we now lack the right kind of physicians to service a national health insurance program should such a program be enacted.

Given the structure that has evolved in the health sector of the economy and the inflationary trend which is a by-product of that structure, our Associations have been compelled to argue for what economists call "segmental caps" or price ceilings on the health care sector.

We do not have all of the answers as to why health care is rising faster in price than other items in the general economy, but we know that it is a fact and that these rising prices are causing great injury to our mass membership. We see no other choice than the adoption of an incomes policy for this sector and the coordination of the various programs, including the Medicare and Medicaid programs, with such a policy.

RECOMMENDATIONS

Our basic recommendation is that physicians should not be allowed to increase their fees in any year over the reasonable charge level (or fee schedule level) for the preceding year at a rate which exceeds the rate of increase in the Consumer Price Index for all services (less medical services). Concommitantly, the Medicare and Medicaid programs should not be allowed to reimburse physicians for their services at amounts in excess of the yearly established ceilings and this same rule should be applied to third-party payments made by private insurers. It is simply not feasible to impose such ceilings only with respect to reimbursement under the Medicare and Medicaid programs. Such action would simply accelerate the trend for physicians to refuse to accept assignment of Medicare payments as payments in full or, even worse, cause physicians to discriminate against Medicare and Medicaid patients. An attempt to deal with inflationary trends in physicians' fees solely through the federal health care programs would make of the beneficiaries of the program second-class citizens.

Having reviewed the physician reimbursement provisions of S. 3205, our Associations question whether they would achieve their intended goals. As with our position on institutional reimbursement, we believe more decisive action is required. The inducements provided in S. 3205, while aimed in the right direction, are not likely to solve the problem at hand. Assignment rates continue to fall despite efforts to encourage physicians to acept the reimbursement rates.

Federal and state regulations which would limit billing amounts would lose most of their force if there were no detailed guidelines for auditing reimbursements to physicians and other providers. State Medicaid administrations should be required to have fraud and abuse units which are adequately staffed and are subject to the federal guidelines. Intermediaries in the chain of reimbursemnt should be subject to inspection along with the records of the physicians and other providers entitled to reimbursement. Finally, we believe that there is a need for an Inspector General of Health Administration at HEW along with a central office of fraud and abuse control.

STATEMENT BY NELSON H. CRUIKSHANK, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, members of the Health Subcommittee, my name is Nelson H. Cruikshank. I am President of the National Council of Senior Citizens, a nonprofit, nonpartisan organization of more than 3,500 older people's clubs across the nation, representing over three million members.

The National Council of Senior Citizens was formed during the long campaign on behalf of Medicare and was in the forefront of the efforts to secure enactment of this important health legislation. We are, therefore seriously concerned about the inflationary tendencies in the medical services sector which threaten not only the financing of the Medicare program, but the adequacy, effectiveness, and access to health care for the entire nation.

Between 1950 and 1975, the percent of our Gross National Product spent on health care rose from 4.6 percent to 8.3 percent, with the greatest rate of increase occurring in the post-Medicare years. To the extent that this is a result of increased access for low-income people and reasonable increases in effectiveness of health care, it is not a priori of concern. However, to the extent that it is a reflection of relative price increases alone, it is of major concern.

According to the Consumer Price Index (CPI), prices rose 6.8 percent for all items (excluding medical care), while medical care service charges rose 10.3 percent in calendar year 1975. Physicians' fees, which represent 18.6 percent of medical service charges, rose by as astounding 11.8 percent. Figures for the first six months of 1976 show a continuation of substantially faster rates of price increases in medical care services than other CPI items. Nor is this an unusual recent development; physicians' fees along with other components of medical care services have been rising at a rate which exceeds that prevalent in the rest of the economy over a number of years. There was a hiatus in medical care price increases relative to other prices in the economy during the period of controls from August 1971 to April 1974, but this was more than compensated for by the surge to double digit price increases after the lifting of controls. Prior to controls, rapid relative price increases occurred after the institution of Medicare, but even before 1966, a strong trend toward relatively higher price rises in the medical care sector was visible.

Relative price inflation in the health care sector of the economy threatens not only the pocketbooks and well-being of consumers, but also from the point of view of society as a whole, the ability for society to establish priorities in the allocation of resources available, and to act upon those priorities. If health costs are permitted to continue along their present path, they will squeeze out other desirable expenditures without even having added to the general level of health of our population. We commend this Subcommittee for its continuing attention to the problem of health care inflation, with particular attention today to the system of physician reimbursement under Medicare.

However, as we stated in our earlier testimony on hospital reimbursement schemes, specific aspects of the problem of rising health care costs may not be resolved in isolation from one another. The problem involves the structure and incentives of the present medical care delivery system and its financing. It is not a problem unique to the Medicare program.

The medical care industry operates similar to a monopoly without the internally generated incentives towards efficiency that are present in competitive industries. Several characteristics of the medical care system that were recently articulated by Walter McClure[1] deserves attention: First, the quality, quantity, and degree of use of high cost styles of treatment are determined by the providers of health care. This means that the medical care system can absorb every dollar made available to it by providing more and more elaborate technology and treatment. Second, incentives on providers in the present medical care system are powerfully skewed toward specialized, technological, high cost care. Thus, unless altered or checked by limited financing, these incentives lead physicians toward elaborate, specialized, high style practice which helps the few at great, great expense rather than lower cost, lower style medicine which helps the many. Third, widespread public and private third-party reimbursement health insurance provides almost open-ended financing to the medical care system. Therefore, neither the provider nor the patient, when he has adequate financial coverage, has any incentive to seek low-cost treatment even though it may be equally as effective as high-cost treatment.

Fourth, because providers operate as small, independent units—predominantly solo physicians—the system neither experiences economies of scale or continuity, nor do they experience the costs of specialized facilities when they hospitalize a patient or share in the savings generated by early detection or prevention of illness. Thus, providers have no incentive to use health resources efficiently. Fifth, the consumer is in no position to judge the effectiveness or efficiency of medical care, particularly at times of illness, and thus offers no check on the decisionmaking of the provider. Sixth, the medical system has no ongoing mechanism for monitoring patient outcomes, nor is any provider accountable for the patient's health beyond individual services rendered. Thus, the system will tend to maximize services rather than health.

For all of these reasons, our present medical care system is characterized by over-elaborate, inefficient, cost-ineffective styles of practice. This does not necessarily mean that medical practices are "bad;" they are simply more expensive and wasteful than methods which could be equally effective in maintaining health at lower cost.

---

[1] "The Medical Care System under National Health Insurance: Four Models," *Journal of Health Politics, Policy, and Law,* Vol. 1, No. 1, Spring 1976.

All of this leads to the important conclusion that there is latitude to contain costs without jeopardizing the health of the nation. However, in order to effect cost containment consistent with the goals of financial protection of people, equal access to medical care and equitable distribution of health care resources, and improved effectiveness of health care, it is important to realize that the entire delivery system needs significant change. Modifications of Medicare will not go far enough. The important questions are where do we want to go and how do we get there? Thus, changes that are discussed in the present hearings should be looked upon as incremental steps toward the long-range goal of a more equitable, efficient, effective, and more financially manageable health care delivery system.

The only proposal which has the potential of meeting all of these goals is the Kennedy-Corman Bill, National Health Security. Operating through a national health expenditures budget which would be allocated across health regions and health service areas through a multilateral planning process, better geographical distribution of medical services could be effected. Additionally, the budgeting system itself would provide strong incentives for better structural arrangements for the delivery of care in the private market, since more efficient and effective delivery would allow greater latitude in negotiating individual rewards.

What we can do then, in the context of physician reimbursement under Medicare which will be consistent with a better medical delivery system? Several suggestions follow.

SUGGESTIONS FOR IMPROVING METHODS OF REIMBURSEMENT OF PHYSICIANS UNDER MEDICARE

The Medicare Handbook in its explanation to beneficiaries about the two methods of reimbursement says that the assignment method can be used only if both the patient and the doctor agree to it. There is no such stipulation with respect to the direct billing method. While it is implied that the physicians and he patient can agree between themselves as to the method of payment, the fact is that the patient has no bargaining power in the situation where presumably the assignment method is discussed. The reality of the situation is that the physician can determine the method of reimbursement which is to be used.

Furthermore, the physican can make that decision with respect to every Medicare patient he sees and force direct billing in one case and assignment in another. He can go even further. He can use the direct billing method with respect to one episode and the assignment method in another with the same patient.

Studies, such as those conducted by the Triangle Research Institute and the Robert Nathan Associates, show that, in general, doctors force the assignment method where there is a risk of collection. Consequently, the assignment method is more widely used in communities or neighborhoods where there is a concentration of low-income people such as in the inner city urban areas. It is also more likely to be used in individual cases where the bill is large. Apparently, in general, doctors are willing to assume what risk there is in collecting smaller bills but will take the assignment method for a large bill. Of course, all this adds to the burden of the patient, since under the direct billing method the doctor is not held to any reasonable charge concept.

Whatever change in the reimbursement method is made, any new plan should include the elimination of this choice on the part of the doctor as to the method of payment. Whatever else is done, he should be required to abide by one or the other method in all cases and under all circumstances.

There are various methods that could be used to overcome the abuses of the direct billing method of payment. One would be to eliminate the direct billing method altogether. This would require physicians to sign up as participating physicians in the program. Accepting the assignment method of reimbursement would be a condition of participating. The Government would make known preferably not only through the SSA, but through public notices—post offices and elsewhere—the names of participating physicians.

It is believed by some that this degree of compulsion would simply drive doctors out of the program altogether. I think it would result in organized medicine putting up a terrific bluff. But I don't think it would follow through. Medicare practice is too lucrative, and while physicians might make a show of resistance, they would not work themselves out of this source of substantial revenue.

Short of this degree of compulsion, it would be possible to provide strong incentives for doctors to use the assignment method. The strongest of such incentive methods would probably be for the Government in the case of assignment billings to reimburse the physician for 100 per cent of the reasonable charge including the coinsurance and deductible amounts. The Government would then take the responsibility for collecting the coinsurance and deductible amounts from the patient. Since practically all the patients are getting Social Security, Railroad Retirement, or Civil Service annuity benefits, it would not be too difficult for the Government to collect these amounts by deductions from these benefits. This would be somewhat complicated, but it would be no more complicated than the deductions from benefits now made under the Social Security program in cases where a retiree earns more than the allowable amount under the retirement test.

The main objection is that it would be confusing to the beneficiaries and about one-third of them in any given year would be confronted with varying amounts in their monthly retirement benefit checks. For these reasons, we would not recommend this drastic incentive plan.

A much less drastic plan would be to allow both methods of reimbursement, but to remove the choice in individual cases by physicians. Participating physicians would have to agree in advance either to accept assignment in all cases with all patients or to rely entirely on the direct billing method. The first alternative, again would entail the Government making available lists of physicians accepting assignment, and requiring physicians to notify patents of their intent in advance.

It would also require negotiated fee schedules which would be developed by representatives of the medical profession and consumer groups with the government in a referee position. The agreed fee schedules should be fair, leaning even towards the generous.

Under this proposal, as at present, the reimbursement is 80 percent of the reasonable charge (as reflected in the fee schedule) and it would be sent directly to the physician. The like amount (80 percent of the reasonable charge after the coinsurance) would be sent to the patient under the direct billing method, leaving the doctor the problem of collecting both the coinsurance and the basic amount of the bill. It is important also that under this method, the government should inform the patient of the method of determining the amount of reimbursement; namely, the normal share of the reasonable charge. If the amount that the physician adds is above the reasonable charge, that amount should be identifiable and clearly indicated to the patient.

However, setting a fee schedule for those accepting assignment under Medicare does not go far enough. ~~The~~ price for a procedure under the assignment method may be set, but the choice of procedures is at the discretion of the provider, as well as the number of procedures employed. Thus, coupled with the existing inefficient medical delivery system, its emphasis on specialization and high-cost technology, and its bias towards financing of the most high-cost options available, constraining physicians' fees by using existing "reasonable charge" concepts is not likely of itself to have a significant impact. Constraining the fees of only *some* physicians—those who accept assigned reimbursement under Medicare—is clearly even less effective, since there is no significant mechanism which constrains price increases for private consumers of medical services. Thus, there may only be a shifting of costs from the publicly insured consumer to the private consumer, or creation of two levels of care, or both.

There is a simple step that could be taken which would work against such price discrimination. The negotiated fee schedules should be public information, available to all consumers, regardless of the source of their financing. The visibility of deviations in pricing policy would add a competitive element to the system and also stimulate debate on what the "reasonable" level of charges should be.

In regard to differentials in reasonable charges between primary care physicians and specialists and between specialists, the rewards should not provide incentives for further specialization unless this is called for in a particular area. Therefore, differentials should be minimized or nonexistent, except in shortage areas.

In any case, prospective budgeting arrangement are preferable to fee-for service reimbursement. Capitation provides better incentives in the use of medical resources by physicians than traditional methods as evidenced by the experience of HMO's. Therefore, one way to contain costs would be to appropriate greater sums for prepaid group practice, and to exclude such practices from "Certificate of Need" regulation to foster the growth of this type of delivery system.

In regard to the potential efficiency of S. 3205 (Talmadge) and its House counterpart, H.R. 13080 (Duncan of Tennessee), we must repeat what was said in our previous testimony before this Committee:

"An examiniation of its specific provision leads us to believe, however, that, although many of them are timely and constructive with regard to needed changes in Medicare and Medicaid administration, including installation of a prospective hospital reimbursement system, the bill falls far short of the comprehensive approach that is now required. We agree with most of its provisions in a narrow context. But, if that bill were to become law, we would repeat the cycle of false hope at the time of its passage; delay, through enormously complicated regulations; and finally frustration and disappointment because the bill cannot achieve control of rising health care prices. Not only that, but there is the potential of an administratively complex regulatory approach actually adding to escalating health care costs."

With respect to the reimbursement of physicians, the bill sets forth a trivial reward system to encourage acceptance of assignment. It offers an extra $1.00 for each patient included on a simplified, multiple listing batch, with a limit of one such payment a week for any individual patient. It is assumed that the physician will save an additional $1.00 in paperwork costs through the simplified billing mechanism. Reimbursement of up to 50 percent of estimated billings is stipulated within five days of receipt of claims. It is hard to believe that a $2.00 reward is sufficient to change the behavoir of physicians when direct billing offers far greater financial rewards. It appears unlikely that this proposal would significantly affect the acceptance of assignment.

SUMMARY AND RECOMMENDATIONS

The problem of rising health care costs is due to the structure and the incentives of the existing medical care delivery system and its financing. Substantial changes in the structure of the model which reverse existing incentives are necessary to contain costs and provide effective care.

Only a national health insurance plan which offers access to all Americans to all levels of the health care delivery system, and which budgets the supply and allocation of medical resources across all the areas of the country and provides incentives for increases in supply tailored to patient needs can offer quality care while constraining costs. The only proposal which fits this description is the Kennedy-Corman Bill (S. 3, H.R. 21), National Health Security.

We urge that the Health Subcommittee of the House Ways and Means Committee, report favorably the National Health Security Bill (H.R. 21) to the full Ways and Means Committee with recommendations for early, favorable action by the full Committee to get the measure to the floor of the House at the earliest possible date.

Prior to its enactment, we urge that reforms in reimbursement for physicians under Medicare include a negotiated fee schedule which is binding under the assignment method of billing in Medicare. We urge that such fee schedules be available for the information of all consumers of medical care to reduce the possibility of price discrimination and to stimulate continuing debate on acceptable levels of charges to all parties concerned. Additionally, the names of physicians participating under the assignment method should be made known through the SSA and through public notices.

We urge that capitation and prepaid group practice be encouraged by expanded appropriations and exclusion from "Certificate of Need" regulations.

We urge that reasonable charge differentials between primary providers and secondary and tertiary providers be minimized or removed (except in shortage areas) to counteract the incentives for overspecialization and high-cost technology.

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present our position on the crucial national issue of rising physicians' costs and the related problems of our total health care system.

MEMPHIS, TENN., *August 16, 1976.*

Congressman DAN ROSTENKOWSKI,
Longworth House Office Building,
Washington, D.C.

DEAR CONGRESSMAN ROSTENKOWSKI: Two days ago I received a call from a member of the Appalachian Regional Commission who requested that I make available to you the enclosed paper and request that it be read into the Hearings on Medicare-Medicaid which will be conducted next week.

This paper speaks to a study conducted here in Memphis and Shelby County and is reported in the *Journal of the American Medical Association*, January 20, 1975. In this system of nurse operated physician-backed decentralized clinics, the need for hospitalization was reduced about 45% after patients entered the program of continuing care when compared to their prior hospitalization experience when receiving care by the usual means. The cost of medical care consequently is significantly reduced.

It is felt that such experience would be of significance in formulating revisions in Medicare and Medicaid legislation and it is for this reason that the request to enter it into the Hearings is being made.

Your help in this matter is much appreciated.

Sincerely,

JOHN W. RUNYAN, Jr., M.D.

Enclosure.

Reprinted from the Journal of the American Medical Association
January 20, 1975 Volume 231
Copyright 1975, American Medical Association

The Memphis Chronic Disease Program

Comparisons in Outcome and the Nurse's Extended Role

John W. Runyan, Jr., MD

IN PREVIOUS communications, the service program in Memphis and Shelby County (Tennessee) for the continuing care of patients with selected chronic diseases has been described.[1-5]

Since the report in 1970,[2] more than 140,000 patient-visits to the decentralized facilities have been made, and patients under regular care now exceed 9,000. The number of urban and rural neighborhood and satellite clinics, which are operated by the Health Department, has been increased to 20, with several more planned.

Although the main efforts have been service oriented and directed toward meeting the medical needs of a large chronically diseased population, some measurements of the effectiveness and acceptability of continuing care to patients in the program and its effects on the course of the chronic illness have been presented recently.[5] This report extends these observations but is primarily concerned with making certain comparisons between patients receiving care in decentralized facilities staffed by specially trained nurses and those rendered care in a more conventional manner in the outpatient clinics of the City of Memphis Hospital.

PATIENTS AND CLINIC SETTINGS

These observations were made on two groups of patients with combinations of three conditions: diabetes mellitus, hypertension, or cardiac disease. The group who received their maintenance medical care principally in the decentralized facilities is called the "study group" and those who received their care in the hospital outpatient clinics are referred to as the "control group." Included in the first group were the 1,006 patients transferred from the hospital clinics to the decentralized facilities located closest to their home over a period of a year beginning Sept 1, 1969; the 498 patients who comprised the second group included all patients who met the following criteria: they had adequate records, sufficient duration of observations, the observations had been made in the same period in a hospital outpatient clinic for chronic disease, and the clinic was staffed by internists. Patients in the hospital outpatient clinic (the medical facility most convenient to their home) had been referred for continuing care after their conditions had been stabi-

Table 1.—Population Characteristics

	No. of Patients	
	Study Group* (n = 1,006)	Control Group† (n = 498)
Men	231	124
Women	775	374
Diabetes‡	797	410
Hypertension‡	515	409
Cardiac disease‡	555	226

*Maintenance care principally in decentralized facilities; mean age of patients, 59 years (range 12 to 93).

†Maintenance care principally in the hospital clinic; mean age of patients, 64 years (range, 15 to 94).

‡The sum of these numbers exceeds the total patients because of multiple diseases in the same patient.

Table 2.—Diabetes-Cardiac Disease-Hypertension Category—Diastolic Blood Pressure in the Study and Control Groups (mm Hg)

	Study Group					Control Group				
Age Group, yr	Mean Before Transfer	SE	Mean† Change	SE	P‡ Value	Mean Before Transfer	SE	Mean Change	SE	P Value
30-39	92.0	3.4	18.7	4.7	NS	...	...	...	...	...
No.	3					1				
40-49	103.0	3.8	−13.6	4.2	<.01	95.0	3.9	−2.3	3.5	NS
No.	17					8				
50-59	95.8	2.1	−7.1	2.7	<.02	95.9	2.8	0.5	2.7	NS
No.	45					35				
60-69	92.4	1.7	−7.3	2.1	<.01	88.5	1.8	0.3	2.6	NS
No.	52					38				
70-79	84.1	2.7	−6.2	2.9	<.05	86.1	2.4	0.8	2.4	NS
No.	27					44				
Over 80	90.0	6.7	−18.7	8.2	NS	80.4	4.1	−0.8	3.8	NS
No.	6					15				
Mean age, yr	61.2	0.9				66.4	0.9			
No.	162					143				

*No patients in age group 10 to 29 years had blood pressure data analyzed.

†Probability of a mean change this different from zero; NS indicates not significant at the .05 level.

‡Mean change derived from after-transfer minus before-transfer blood pressure, mm Hg.

From the Division of Health Care Sciences, departments of medicine and community medicine, University of Tennessee College of Medicine, Memphis.

Reprint requests to 800 Madison Ave, Box GA150, Memphis, TN 38163 (Dr. Runyan).

Table 3.—Analysis of Age-Adjusted Changes in Diastolic Blood Pressure and Blood Glucose—All Patients

Disease Categories	No. of Patients		Blood Pressure		Blood Glucose	
	Study	Control	F Value*	*P*	F Value	*P*
Diabetes only	94	20	...	...	13.11	<.001
Hypertension only	139	36	31.14	<.001	...	...
Diabetes-cardiac disease	14	26	...	...	0.05	NS†
Diabetes-hypertension	132	17	...	...	4.37	<.05
	158	26	6.87	<.025	...	...
Cardiac disease-hypertension	216	194	21.27	<.001	...	...
Diabetes-cardiac disease-hypertension	123	114	...	...	0.17	NS
	150	141	15.87	<.001	...	...

*With significant F values, the study group reductions in blood glucose and blood pressure were always greater than those in the control group.

†NS indicates not significant at the .05 level.

Table 4.—Hospital Days per 1,000 Patients per Year

	Study			Control		
	Before	After	% Change*	Before	After	% Change
Diabetes	3,319	1,680	−49.4	1,261	2,107	+67.1
Hypertension	2,509	1,196	−52.3	1,966	2,671	+35.9
Cardiac disease	3,074	1,560	−49.3	2,129	3,084	+44.9
Total	3,439	1,603	−53.4	2,499	3,573	+43.0

*Percent change = ([after value − before value]/[before value]) × 100.

Table 5.—Total Hospital Days—Analysis by Age Decades, Study vs Control

Age Decade	Study			Control		
	Before	After	% Change	Before	After	% Change
10-29	204	77	−62.3	60	155	+158.3
30-39	486	210	−56.8	80	169	+111.3
40-49	864	256	−70.4	271	167	−38.4
50-59	1,370	725	−47.1	504	471	−6.5
60-69	1,383	680	−50.8	602	707	+17.4
70-79	797	365	−54.2	597	1,199	+100.8
Over 80	321	138	−57.0	236	274	+16.1

lized in various other clinics in the hospital. Some had been participants in phase three drug-evaluation studies (antihypertensive and antidiabetic drugs) in the past. None of the patients was a participant at the time of these evaluations. The first clinic visit in the year beginning Sept 1, 1969, was considered the reference date or point of "transfer" of the patients. Observations extend for two years before and after transfer. As the need arose, both study and control patients were referred to the various hospital speciality clinics or to the General Medicine Clinic if a detailed reevaluation was indicated.

The two populations were of similar socioeconomic backgrounds, with comparable men-to-women ratios (Table 1). Hypertension was more prevalent in the control group while cardiac disease was more prevalent in the study group. The mean age of the study group was 59 years and of the control group, 64 years. Because of the frequent occurrence of multiple diseases in the same patients and incomplete data on some patients, the totals in the analysis of blood pressure and blood glucose vary from the figures given in Table 1.

STATISTICAL METHODS

Preliminary testing indicated minimal base-line variable differences between the study and control groups and also few differences by sex. Consequently, all comparisons were made with men and women combined. However, there were significant differences in age in some of the patient subgroups and to allow for these, age-adjusted comparisons were made. Our major interest was in the analysis of variable changes, ie, after-transfer values minus before-transfer values in the study and control groups. The significance of these variable changes within the two groups by decades of age was tested with the paired t test. Age-adjusted comparisons of variable changes in the study and control groups were made by the analysis of covariance with patient age as the control variable.

RESULTS

Clinic Visits and Professional Contacts

As previously reported,[5] professional contacts increased in frequency in the study group after transfer from the medical center to decentralized facilities with home visits. In contrast, clinic visits were found to decrease after the transfer date in the control group, with 6,488 visits/1,000 patients/yr before transfer and 5,503 visits after transfer. Accurate information on emergency room use is not available for the control group, but in the study group this use decreased.[5]

Blood Glucose and Diastolic Blood Pressure Levels

We analyzed the data relating to diastolic blood pressure and blood glucose for patients in the following disease groups: hypertension only, diabetes only, diabetes-cardiac disease, diabetes-hypertension, hypertension-cardiac disease, and diabetes-cardiac disease-hypertension.

The method of analysis of the data relating to diastolic blood pressure and blood glucose is illustrated by Table 2, which gives the data on diastolic blood pressure for the diabetes-cardiac disease-hypertension category of patients. The mean blood pressures prior to transfer and the mean changes in blood pressure following transfer are shown by age decades. The mean change in blood pressure is calculated from the patients' distribution of after-transfer values minus before-transfer values. Hence, a negative (−) value for mean change shows that the patients, on the average, had a lower blood pressure after transfer. The standard errors (SEs) of the means are also shown. The *P* values indicate whether the mean changes within a particular age decade differ significantly from zero.

Table 2 shows that the study group of patients in all age decades except the 30- to 39-year-old age group (only three patients) had lower blood pressures after transfer and that these reductions were significant in all ages except among those 30 to 39 and over 80 years of age. In the control group blood pressures were reduced among those 40 to 49 and over 80 years of age, but none of the changes differed significantly from zero. Overall, the control group was significantly older than the study group ($P < .05$).

The data for the variable changes in Table 2 and for the other five disease groups listed above are summarized in Table 3, which shows the age-adjusted comparisons between the study and control groups.

Table 3 shows that study patients with hypertensive disease always experienced significantly greater age-adjusted reductions in diastolic blood pressure as compared to the control subjects. Reductions in blood glucose levels were found in the study group in all disease categories that included diabetes when compared to control subjects, but the F values were only significant in two disease categories: diabetes and diabetes-hypertension.

Hospital Inpatient Utilization

The number of hospital days/1,000 patients/yr for patients in each disease category in the study group for the two-year period before transfer was greater than in the control group (Table 4). In the two-year period after transfer, the study group, who were provided maintenance care in decentralized facilities, utilized approximately 50% fewer hospital days, while the control group showed an increase in hospital days for each disease category. The data relating to total hospital days in the study and control groups by age decades are shown in Table 5 and the age-adjusted changes are shown in Table 6. The analysis of the changes in hospital utilization (Table 6) after transfer in the study group showed that utilization was reduced in all age decades, whereas the control group only experienced reductions in the 40- to 59-year-old age groups.

For an overall comparison of the two groups, we tested the age-adjusted changes in hospital utilization by the analysis of covariance with the age of each patient as a control value (Table 5). The changes consisted of the number of hospital days after transfer minus before transfer hospital days in the study and control groups. This calculation showed that in all three main disease categories, the study patients had significantly reduced hospitalization compared to the controls.

Primary Causes for Hospital Utilization

The three major disease categories—hypertension, diabetes, and cardiac disease—were examined without regard to associated diseases (Table 7). We analyzed the data in these broad categories because of the relatively small numbers of patients hospitalized when broken down into the previously analyzed categories plus cardiac disease only. For the study group, some of these data in a different form have been presented but without the control group data.[5] In the study group with *diabetes*, hospital days devoted to the categories of (1) diabetic acidosis and severe infections, and (2) peripheral vascular disease and amputations declined (61% and 68%, respectively) after transfer, while in the control group the number of hospital days for the first category increased 17% and for the second category, decreased 13%. Number of hospital days resulting from vascular and renal diseases increased in both study and control groups but increased to a greater extent in the control group. In the study group with *hypertension*, hospital days for stroke, organic heart disease, and congestive heart failure decreased after transfer, while an increase occurred in the control group. Both study and control groups showed an increase in hospital utilization after transfer for patients with renal insufficiency and myocardial infarction. In those with *cardiac disease*, hospital utilization in the study group for organic heart disease and congestive heart failure decreased after transfer, while a significant increase in hospital utilization occurred in the control group. Also, hospital days for

Table 6.—Total Hospital Days—Analysis of Age-Adjusted Changes, Study vs Control

Disease Group	No. of Patients		F* Value	P
	Study	Control		
Diabetes	223	103	24.73	<.001
Hypertension	271	170	17.09	<.001
Cardiac disease	205	181	18.44	<.001

* The F values reflect a greater decrease in hospital utilization in the study patients following transfer.

Table 7.—Hospital Days per 1,000 Patients per Year

	Study			Control		
	Before	After	% Change	Before	After	% Change
Diabetes						
All causes	3,319	1,680	−49.4	2,728	4,838	+77.3
Diabetic acidosis-infections	900	350	−61.1	587	688	+17.2
Peripheral vascular disease and amputation	626	201	−67.9	436	379	−13.1
Renal, cardiovascular	388	505	+30.2	355	1,523	+329.0
Hypertension						
All causes	2,509	1,196	−52.3	2,395	3,238	+35.2
Stroke	281	102	−63.7	72	201	+179.2
Myocardial infarction	54	56	+3.7	80	239	+198.8
Renal	56	139	+148.2	0	93	...
Organic heart disease and congestive heart failure	136	131	−3.7	411	699	+70.1
Cardiac disease						
All causes	3,074	1,560	−49.3	2,594	3,739	+44.1
Myocardial infarction	89	87	−2.2	80	269	+236.3
Renal	87	216	+148.3	0	60	...
Organic heart disease and congestive heart failure	366	221	−39.6	465	857	+84.3

myocardial infarction increased in the control group.

Mortality

Although a two-year period of observation has limited value in terms of mortality data, 7% of the study population and 11% of the control population died in this period. As would be expected, those 70 years of age and older had the higher death rates in both study and control populations. However, there were no statistically significant differences in death rates in the two populations when examined by age decades.

COMMENT

A number of factors may have contributed to some of the differences in the measurements, observations, and patient-care experiences in the two populations with combinations of the three conditions: diabetes, hypertension, and cardiac disease. Were the study and control populations dissimilar enough to account for these differences? The mean age in the control group was significantly higher than that in the study group. However, comparisons were made by age decade and analysis of covariance that removed age differences as a factor in the observed outcome. On the other hand, in examining some of the clinical features of the diabetic population in the preceding two years, it was seen that incidence of a history of diabetic acidosis and amputations was higher in the study group than in the control group; also, the study group had higher blood glucose levels before transfer and more days spent in the hospital. In both the *hypertensive and cardiac disease* populations, hospital utilization was greater for the two-year period before transfer in the study group than in the control group. Hospital utilization for renal disease with its recognized relationship to both diabetes and hypertension was more prevalent in the study population before transfer. Although the problems of relating two populations with multiple risk factors are recognized, the data do not suggest that the study population were at less risk than the control population, and there is evidence that the opposite may have been the case.

Those in the study group received maintenance care in decentralized facilities by nurses, and therefore, several factors were introduced that are considered to have favored the outcomes observed. Professional care and advice are easier for the patients to obtain when the barrier to care of a rigid appointment system, characteristic of the hospital clinic, is removed. Patients are given the opportunity to call, if in need of medical assistance, and appropriate advice is given or home visits are made, if found advisable. During 1973, more than 8,000 home visits to these chronically diseased patients were made. The same medical protocols and opportunities to obtain selected laboratory tests prevail whether the patient is seen in the decentralized clinic or home. Missed appointments are followed up. Drugs are actually dispensed directly to the patient when being seen by the nurse, which gives the opportunity for patient education and counseling, and it is believed that patient compliance is greatly enhanced as a result. Goals of therapy for hypertension and diabetes and the means to achieve them are stipulated in the protocols used by the nurses. Physicians' attitudes toward hypertensive therapy have been commented on,[6] even though the benefits of therapy have generally been recognized since reports of the Veterans Administration study on hypertension conducted by Freis.[7-8] In in-service training sessions and the protocols, the early recognition of cardiac failure and digitalis intoxication with appropriate follow-up action is emphasized to the nurses, and this factor may contribute to the favorable experience with patients with cardiac disease in the study group.

Prevention of diabetes and essential hypertension is not a reality at present. Control of these diseases, which is possible but not always attained in a public hospital setting, leads to a reduction in those complications that are associated with increased mortality, morbidity, and hospital utilization.[7-9] The Memphis Chronic Disease Continuing Care Program makes available to patients in a systematic manner the basics of good medical practices: accessibility to care, patient education and counseling, follow-up, home visits, selected effective medications, laboratory test monitoring at intervals, realistic goals of therapy, and appropriate referrals and contacts with the back-up physicians and the medical center.

The observations in this report give further support to the concept introduced nearly 12 years ago that nurses can effectively share a large and increasing responsibility in chronic disease care. In the EDITORIAL in THE JOURNAL[4] relating to the Memphis Program, the question was asked "should the nurse, even after special training, have this much autonomy in the regulation of uncontrolled glycosuria, the delicate balancing of blood pressure between too high and too low with potent antihypertensive drugs and the adjustment of digitalis dosage?" With detailed protocols and physician and medical-center backup, the data presented here indicate that this question can be answered in the affirmative.

These investigations were supported in part by a grant from the Robert Wood Johnson Foundation.

George S. Lovejoy, MD, Director of the Memphis and Shelby County Health Department and the staff of City of Memphis Hospital, helped in program development and collection of data. Marion G. Baker assembled the data. Harry Robinson, ScD, assisted with statistics.

References

1. Guthrie N, Runyan JW, Clark J, et al: The clinical nursing conferences: A preliminary report. *N Engl J Med* 270:1411-1413, 1964.
2. Runyan JW, Phillips WE, Herring O, et al: A program for the care of patients with chronic diseases. *JAMA* 211:476-479, 1970.
3. Physician's assistant or assistant physician?, editorial. *JAMA* 212:313, 1970.
4. Runyan JW: Physicians' assistants: Nurses as physicians, letter to the editor. *JAMA* 213:1037, 1970.
5. Runyan JW: Decentralized medical care of chronic disease. *Trans Assoc Am Physicians* 83:237-244, 1973.
6. Stokes JB, Payne GH, Cooper T: Hypertension: The challenge of patient education. *N Engl J Med* 28:1369-1370, 1973.
7. Effects of treatment on morbidity in hypertension: Results in patients with diastolic pressures averaging 115 through 129 mm Hg, Veterans Administration Cooperative Study Group on Anti-hypertensive Agents. *JAMA* 202:1028-1034, 1967.
8. Effects of treatment on morbidity in hypertension: II. Results in patients with diastolic blood pressures averaging 90 through 114 mm Hg, Veterans Administration Cooperative Study Group on Anti-hypertensive Agents. *JAMA* 213:1143-1152, 1970.
9. Miller LV, Goldstein J: More efficient care of diabetic patients in a county-hospital setting. *N Engl J Med* 286:1388-1391, 1972.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., September 1, 1976.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, House Committee on Ways and Means, Washington, D.C.

DEAR MR. CHAIRMAN: In the enclosed letter from Eugene E. Smith of Wichita, Kansas, he discusses the increasing costs of medical care, citing his own experience, as a Medicare patient, in a local hospital.

Perhaps this information will be helpful to the Subcommittee which will reschedule at some future time the hearing on "recommendations relating to revisions in the Medicare physician reimbursement system."

Sincerely,

GARNER E. SHRIVER,
Member of Congress.

WICHITA, KANS., *August 7, 1976.*

GARNER SHRIVER,
U.S. Congressman for Kansas,
Washington, D.C.

DEAR CONGRESSMAN: I am writing this letter with some disbeliefs in regard to the ever increasing costs of medical care in these United States.

I am thankful that the leaders of this nation added hemodialysis patients to the group of recipients to medicare; without this assistance we would be on welfare and completely bankrupt.

Let me brief you on my condition: Starting January 1969 it was necessary to start on hemodialysis because of kidney failure, treatments are three times per week in our home. At that time the only assistance we had was company insurance, which did help pay some of the expenses; we had to cash bonds and draw out the little bit of savings we had.

When "Medicare" started helping it lifted a large burden from us! We truly appreciate the help it has been. You may be aware of the medical expenses as they are today, but I would feel negligent if I did not bring this to your attention.

After a 10 hour stay in the hospital July 4th, 1976 I could not believe the charges sent to me as final bills, I will include copies of these. I was hospitalized to replace the veninous side of my cannula shunt which is in my left arm; the surgery took a total time of 45 minutes and was done with a local anethetic.

The charges are as follows:

Total charges for 10 hours hospitalization	$834
Surgeons fee for 45 minutes	390
Ambulance fee for 125 miles	150
Charges for July 4, 1976	1,374

Perhaps some kind of controls should be put on charges for certain types of surgery etc. (If they are unable to control themselves on overcharging their patients.) It seems that hospitals run tests that are unnecessary. I ask you and the other members of Congress, is anyone worth the wages of $520.00 per hour? This is what the surgeons fees amount to!

I am enclosing copies of the three bills mentioned—The ambulance fee was due to us being 185 miles from Wichita, and after starting to Wichita the car heated at 3:00 a.m., and no one in that area is familiar with the shunt and kidney machine so with my arm bleeding, it was necessary to use an ambulance.

Many people say, "So what", Medicare pays 80 percent. They seem to think that they are not a part of the government, but we are paying for these things with our taxes. (I am still working full time) (Even if I weren't I don't like to be charged an unreasonable amount regardless of who is paying for it.)

Sincerely,

EUGENE E. SMITH.

PETITION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

I, Samuel B. Wallace IV, a citizen of the United States, petition the Secretary of Health, Education, and Welfare, for a change in FDA Regulations to permit the public to purchase antibiotics in small quantity capsul form over the counter.

The reasons for this petition are as follows:

1. The common antibiotics when taken in small quantities at their proper strength in either capsul form or in nasal nosedrops are the most effective medicines known to man in treating respiratory illnesses and other common illnesses in very short periods of time.

2. There is now no absolute guarantee of the accessibility of these medicines for the general public in times of serious need due to illness whether the sick person avails himself of a doctor's care or the care of a clinical physician or hospital or whether he does not, since the doctor may or may not prescribe the antibiotic for the treatment and cure of respiratory illnesses due to the physicians own personal medical theories or foibles concerning antibiotic medicines.

3. There have been at least 14,000 deaths due to influenza alone in the United States for each year for the past three years and it is obvious that in many instances the physician did not prescribe antibiotics nor did the patients have access to the antibiotic medicines otherwise the number of deaths due to influenza and other respiratory illnesses would have been substantially lower than the number of deaths indicated by those figures.

4. The commonly known antibiotics can be sold by the pharmacists in relatively small quantities and at such mild strengths that there is no harm done to the ordinary patient who is taking such antibiotics in strengths of 500mg. per capsul would be taking a medicine far less subject to reaction than say ordinary aspirin or analgesics of that type sold over the counter without a doctor's prescription.

5. The taking of antibiotics in small quantities at relatively mild strengths would not be in conflict with the spirit of FDA regulations for antibiotics such as cough medicines that can be obtained at a far higher strength with a doctor's prescription according to FDA regulations.

6. Since the use of these antibiotic medicines are permitted at a higher strength with a doctor's prescription is sanctioned by the FDA there is no reason that such medicines should not be made available in small quantities at much milder strengths, since the application of such medicines are the only guarantee that the cure of the common cold or influenza or pneumonia or other respiratory illness can be achieved in 100 percent or nearly 100 percent of the time. And since there is no guarantee that such medicines will ever be made available to the general public unless, the public is permitted by law to purchase such medicines without a doctor's prescription at the local pharmacy.

7. This petition does not conflict with the norms of practice among the better physicians in America and elsewhere in the world, nor does it conflict with the general practices as advocated by the FDA as recorded in the Federal Register concerning the use of such medicines with a doctor's prescription. Therefore, I petition the Secretary to permit the pharmacies to sell such medicines in small quantities in relatively mild strength (600mg per capsule to adults) over the counter without a doctor's prescription because otherwise there is no guarantee that such medicine will be made available to the public when individuals are sick even when such medicine is requested by the patient himself from his own doctor or from an attending physician.

Samuel B. Wallace,
Petitioner.

Clairfield, Tenn., *August 31, 1976.*

Congressman Dan Rostenkowski,
U.S. House of Representatives,
Washington, D.C.

Dear Congressman Rostenkowski: Thank you for your visit of July 22nd to the Clear Fork Clinic at Clairfield, Tennessee. Your sincere interest in our facility, and your reassurances concerning the future status of clinics like the one at Clairfield were greatly appreciated. I hope the information that you derived during the visit will assist you in making decisions regarding national health legislation. My role at the Clear Fork Clinic is fairly typical of those, which Physicians' Assistants are fulfilling in many other medically underserved areas.

One matter of concern to me, which we did not discuss during your visit is that of credentialing physician extenders. As you know, a proper credentialing mechanism is the one safeguard, which serves to insure the public, that a trained medical professional is indeed qualified to deliver services safely and effectively. Currently, in order to become certified, a Physicians' Assistant (PA) must be a graduate of an AMA-approved training program, and he or she must pass a rigorous examination, which has been developed by the National Commission on Certification of Physicians' Assistants. The exam is administered by the National Board of Medical Examiners (NBME). However, to my knowledge, graduates of extended nursing programs to train nurses for Physician extender-type roles are not required to demonstrate any level of competency, beyond that required for the basic nursing licensure examination—they can take the NBME exam if they *choose* to do so.

As both a Registered Nurse and a Physicians' Assistant, I am acutely aware of the very significant differences, between what is the nursing role, and what is the physician extender role. Many programs to train nurses for PE-type roles were hastily developed and implemented without much guidance from the medical profession. Thus, some such programs are conspicuously lacking in duration, scope, intensity and/or quality of training. Moreover, the current credentialing situation for nurses is sufficiently ill-defined, that graduates from a wide variety of nursing programs can potentially assume the broader physician extender role, even though in many instances they would be ill-equipped to do so. In view of the foregoing, I submit that any responsible national legislation to reimburse physician extenders for their services should require, that all types of PE's be certified via a common credentialing mechanism. The aforementioned NBME exam could provide a logical, high quality basis for such a requirement.

I have enclosed a copy of a report from a Georgetown University study of the services provided by the various types of physician extenders. I must caution, that such studies are not indicative of the ultimate potentials of the PA professional. The PA is a true careerist, who has been given the essential tools via the medical sciences for expanding his or her knowledge of medicine. Thus, PA productivity should increase and PA role potentials should expand, if PA's are given the time and the legislative support to prove their full worth. We do not have the powerful lobbies of other professions, but we are "trying harder" in places like Clairfield, Tennessee.

I have also enclosed a copy of our utilization report for the months of June and July, because I think this information is revealing. I anticipate that similar data for the month of August will show a comparative increase in utilization of the clinic by the local population. I should stress that I have been practicing as a PA for a relatively brief period of time. Also, many of the patients seen by supervising physician, Dr. Jesse L. Walker, are seen by him of necessity, because they are Medicare patients. Possibly, the most revealing indicator, however, is the feedback I've received from my patients. Initially, they called me "the nurse". Now despite my encouraging them to call me "the assistant", many of those who I've seen more than a couple of times choose to call me "the doctor". Thus, between the nursing role and the physician role there exists a very tangible role, which Physicians' Assistants can and should fulfill in health care delivery.

Last, I must tell you that I am opposed to the current trend of allocating large amounts of money to train more physicians for primary health-care delivery. I, for one, cannot foresee that the next generation of physicians will manifest a greater willingness to serve in medically underserved areas. The basic nature of this problem has deep socio-economic, cultural, and psychologic roots, which will not dissolve by providing financial incentives, by training more physicians, or by training more individuals from socio-economically disadvantaged groups to become physicians. Let it suffice to say, that a new breed of medical professional is needed. Physicians' Assistants are a new breed of medical professionals, who hold the greatest promise for meeting the needs of our nation's medically underserved populations.

Thank you very much for considering these issues.

Sincerely,

Charles S. Ward, R.N.–P.A.(C).

Project Officer's Final Report, Contract N01–MB–44171, Georgetown University

I. BRIEF SUMMARY

A. Background

In January 1974, the Office of Special Programs (OSP), Bureau of Health Resources Development (now Bureau of Health Manpower) launched a program to solicit projects which would heighten the awareness of physicians about the utilization of physicians assistants. There were twelve projects which resulted from this effort and Georgetown University was awarded a contract to expand the analyses of a major study of a medical service area being conducted for the Appalachian Regional Commission (ARC). Private foundation support had financed the gathering of data and the ARC was to support the processing of the data as well as integrate it into the total health planning efforts of the state of Maryland. The Bureau's investment would support an assessment of how many physician extenders, physician's assistant, MEDEX, and family nurse practitioners, can be employed within an area and what functional differences exist among them in proportion to the disorders they can care for in part or in total based on the data about health care delivery known at that time.

The contract called for Georgetown University to analyze population based data from a medical service area, the data from physician contacts recorded during the survey gathering process (which represents all ambulatory primary care for the area) and assess the extent to which the three types of physician extenders could have handled the care delivered to that population.

Early in August of 1974 negotiations with ARC were terminated presumably because the Commission was scheduled to cease its activities. Since analysis of the data for the Bureau's purposes was dependent upon a major funding source, the contractor was unable to code and analyze material as rapidly as previously scheduled. This factor was a major element in the subsequent request for an extension to the contract of six months. Furthermore, the Project Director was unexpectedly named Acting Chairman of his department which refocused many of his hours from this project to his primary responsibilities at the University.

Also, expected cooperation from the Association of Physicians Assistant Programs, for names of physician employers to be used as consultants to this contract, was determined not legally feasible. The process of obtaining names and addresses of physician consultants was therefore prolonged. Finally, toward the end of the contract it became apparent that the amount of analysis to be done before the termination of the contract could be greatly facilitated by the use of a subcontract with Biometric Research Institute. There were no additional funds needed for this activity and the modification to the original contract was granted.

B. Methodology

The delegability of medical care functions to personnel other than physicians was approached by determining first—the proportion of a community's ambulatory care services which are primary care, and second—based on the expert opinions of three panels of six physicians representing three distinct physician extender programs—a determination was made of the proportion of these primary ambulatory care services that could be handled by the different physician extenders.

The contractor developed an operational definition of primary care based on the Alpert and Charney definition.[1] This was reviewed and approved by Physician Assistant educators, graduate physician's assistants as well as practicing physicians and the Project Officer. Three board certified family practitioners, using this definition then reviewed the patient contact forms for all physician visits in the service area. The specialty of the physician about whose practice the information was collected remained unidentified. A pretest was administered to the reviewing physicians, final discrepancies in coding were corrected through discussion until total agreement was reached and all forms were divided into primary and non-primary care.

The contractor then assembled and instructed three panels of six physicians to each panel to determine the proportion of ambulatory care which primary care physician extenders can handle. In each panel, there were three physicians who employed Physician Extenders in their primary care practice and three educators of each one of the three kinds of physician extenders. The panelists were asked to designate whether in their professional opinion the type of physician extender with which they were familiar could assume responsibility for ALL, SOME or NONE of the professional care for the patient contact. The results were analyzed for within and across panel variations by the different physician extender panels and by sub-panels of physician extender educators and employers. Results were then analyzed for the extent of delegation of care within several morbidity categories using the following indices: (a) most frequent diagnoses, (b) broad category diagnoses, (c) multiple or single diagnoses, (d) preventive care versus curative and site of visit—phone or face-to-face.

---

[1] See attachment A.

C. Findings

There were 990 observations forms recording 1.332 ambulatory visits of which 17 percent were made by phone and 83 percent were face-to-face. Seventy-seven percent were determined to be of a primary care nature. Seen as a whole, physician extenders were deemed capable of handling at least some part of 92 percent of primary care visits. They could substitute completely for physicians in 48 percent of visits and could care for some part of 43 percent of visits. Employer and educator physicians differed somewhat in the proportion of all care which they viewed the physician extender as capable of handling—employers 43 percent versus educators 54 percent.

Although all three panels agreed that on the basis of their professional general knowledge of the capabilities of the three types of PEs, the physician extenders with whom they worked and others of their type, were capable of handling most primary care, MEDEX physician extenders were seen as capable of assuming total responsibility for less care than physician assistants or nurse practitioners. However, of those cases in which the physician extender was felt to be able to assume some responsibility, nurse practitioners were felt to be able to care for less by themselves than physicians assistants or MEDEX. Within morbidity categories, physician assistants were consistently ranked the highest by average scores indicating they could assume more responsibility than the other two physician extenders. Nurse practitioners consistently ranked lowest except for handling mental disease and complications of pregnancy.

According to the findings, nearly 7 out of 10 non-hospital patient contacts can be cared for in all or part by any one of three major groups of physician extenders currently being trained.

In the course of analyzing the patient encounters for this medical service area, using the criteria specified in Attachment A, (the operational definition of primary care), it was determined that by dividing office practice physicians into primary and non-primary care practitioners, nearly all (96%) of the total ambulatory care that primary care physicians provide is primary care. Of the total ambulatory care delivered by non-primary care specialists, 57 percent is primary care. Eighty-eight percent of care given by OB/GYN physicians is primary care and more than half of ambulatory care given by general surgeons and even medical sub-specialties is primary care. Only surgical sub-specialties provide predominantly non-primary care. The comment was made that the results question the advisability of training many non-primary care specialists who will spend a substantial part of their ambulatory care practice providing primary care which could be better provided by primary care physicians or by physician extenders.

II. EVALUATION OF THE PROJECT

The study has provided an appreciable assessment of the extent of ambulatory care which is delegable to physician extenders. Since the late sixties, the literature has reflected a steady and increasing recognition of the possibility of task delegation, then the results of actual experiences of various types of physician extenders in individual practices to whom tasks were delegated. Concurrently, various articles examine the detailed activities of physicians in order to determine which activities could be performed by non-physician personnel.[2]

This contract has supplemented these studies by categorizing a medical service area, a natural catchment area for which a total health care system could be planned, and giving a broader picture to the substitutability potential of physician extenders for a given population with given morbidities.

The study can be considered important for the insight it gives into the extent to which different types of physician extenders are considered capable of providing primary care. Physician extenders are not a homogeneous group. Variables such as institutional selection processes, curriculum content and structure of program, individual personalities, and employer/employee relationship may well be contributing factors to the different competencies among sub-groups with the main categories of physician extenders. It may be that differently trained physician extenders will be able to care for different proportions of illnesses seen in medical practice and that the substitutability of one physician extender for another should be considered.

The report statistically analyzes and comments on the differences that exist between what educators feel physician extenders are trained to do and how practicing physicians feel they can be used in their practices. If physicians delegate fewer responsibilities than they are trained to handle, physician extenders are under utilized. If the physician delegates more responsibilities than the physician extender is trained to handle, the physician extender is being over utilized to the danger of the public and to the possibility of a lawsuit. The contract appears to be quite useful in assisting health planners to determine what requisite data sets are needed to accurately estimate the need for physician extenders and, then based on their population's need for primary care, to determine the different basic types of physician extenders for potential employment. In this regard, the contractor has pioneered in proposing a methodology by which systems analysts and health planners could rationally approach the projection of health manpower development for a Health Service Area.

---

[2] Baker, Collins, M.D., What's Different About Family Medicine?. JME, March 1974, pp. 229–235.

The Georgetown staff supported by the contract included a Principal Investigator, Dr. David Rabin, an Administrative/Research Associate, Ms. Kristin Spector, a part-time secretary and a part-time programmer. The daily management of this contract fell heavily on Ms. Spector's shoulders due to Dr. Rabin's other commitments. The scope of work was adequately fulfilled, however, and despite apparent major problems at various points along the way, the contract appears to have been a wise investment of a minimal amount of money, $28,718.

III. MONITORING OF CONTRACT

The activities of the Georgetown staff were monitored through the following:

1. Monthly phone calls to either Dr. Rabin or Ms. Spector.
2. Quarterly written reports from Dr. Rabin.
3. Material such as pertinent articles or names of suggested consultants were sent or telephoned to Dr. Rabin at various points along the way.

4a. August 23, 1974—Project Officer initiated an introductory/orientative visit to Georgetown University.

b. April 23, 1975—Project Officer and one Division of Medicine staff visited Georgetown for a status report and discussion about the anticipated extension needed.

IV. DISSEMINATION OF PROJECT RESULTS

The Principal Investigator has prepared two articles, which are the results of this study, for submission to health related journals such as New England Journal of Medicine. The Final Report has been sent to Principal Investigators of other completed, Bureau funded research on Physician Assistants. Most importantly, along with other recently completed Final Reports, it will be analyzed for general trends and conclusions about Physician Assistant utilization which then can be the basis for decisions to be made about Departmental Policy on the education and utilization of physician's assistants. The projected substitutability of physician extenders for physicians has been used in forecasting formulae designed for health manpower development projections.

V. PROPOSED ACTION

This contract was developed to augment a host of different projects all of which were directed toward increasing our understanding about the physician's assistant and, then, to make the subsequent results known to the health professional world. The technique used supplements information gleaned from direct observations and mathematical modeling. There are deficiencies in the results because there were no analyses made of the activities of private-office-based primary care physicians while in the hospital setting and the subsequent potential delegation of activities to physician extenders. The wide range of competencies within sub-groups of physician extenders is not considered in any aspect of the study. It might be useful to have the profiles of the study practices compared with other published practice profiles and hazard a guess as to the applicability of the amount of delegation possible in those practices. For the present, however, this study presents a relatively non-complicated method of determining manpower employment potentials for health planners.

VI. SUMMARY OF THE METHOD

Using an operational definition of primary care, the contractor directed three practicing physicians to code all ambulatory care encounters documented through survey technique in one medical service area into primary and secondary encounters. The primary care encounters were then given to three separate physician extender employer and educator panels for a determination, based on professional judgment of the differences in utilization of the three basic types of primary care physician extenders: Medex, two year physician's assistants and nurse practitioners (PRIMEX).

ATTACHMENT A

DEFINITION OF PRIMARY CARE

Primary care is that medical care which has one or more of the following characteristics:

(1) The patient presents with a new complaint for assessment which may be either a sign or symptom.

(2) The patient requires continuing maintenance care for a stable chronic, uncomplicated disease. This care is shared with the specialist at time of initial diagnosis, reevaluation or exacerbation of the chronic disease.

(3) The patient needs coordination of care rendered by two or more subspecialists. This coordination is needed for care of the individual or his family unit where persons have multiple disorders which require periodic specialty care.

(4) Assessment and treatment of minor trauma or referral to specialty care for further assessment and treatment of trauma.

(5) The patient desires counseling on acute or chronic mild neurotic disorders of personal, child or family developmental problems.

(6) The patient requires maintenance in normal physicologic states such as pregnancy as long as the state is uncomplicated.

(7) The patient requires modificiation of normal physiologic fuctioning as in use of oral contraceptives to prevent conception.

(8) The patient needs preventive care such as routine preventive measures like immunization, vaccination and periodic assessment for maintaining the health of the individual or detecting presymptomatic disease.

(9) The patient requires an administrative procedure, e.g., certification of the state of his health for life insurance.

Primary care can be provided by specialists as well as primary care physicians. Where it is provided by specialists, it duplicates an activity which could be effectively carried out by a physician trained in primary care, although it is appropriate that the specialist provide such primary care if he has assumed responsibility for the clinical episode, e.g., removing stitches for a laceration, in order to maintain continuity of care.

[Mr. Ward included some material which is not decipherable. It is retained in the subcommittee files.]

STATEMENT OF THE WEST VIRGINIA COMMITTEE FOR THE HEALTH SECURITY ACT, IVAN ASAY, MEMBER

Our statewide committee for the Health Security Act strongly agrees with your subcommittee in its concern "that the present system used to determine the amount medicare will pay for a physician's service (reasonable charge) is not able to address adequately all these objectives": (1) "Adequate financial protection for beneficiaries," (2) "rational payment patterns for physicians' services," and (3) "avoiding inflationary tendencies in the program."

We believe a fourth objective should be added: (4) to help overcome the shortage of accessible medical manpower and facilities in rural areas such as are prevalent in West Virginia. The reimbursement system should preferably have a positive influence and certainly avoid a negative impact on the increase and better distribution of health services.

HIGH PRIORITY ACCORDED HEALTH CARE

My own work as a volunteer throughout the State has been mainly with programs on aging. One organization with which I work, the Council of Senior West Virginians, does research on current needs and priorities of the elderly. Invariably, we find the gap in home health and other primary care to be very high on the priority scale. If this is true for persons eligible for medicare and medicaid, the gap is even more serious for those not yet eligible. Testifying to this, a neighbor very recently exclaimed to me, "If my wife had not happened to become eligible for medicare just in time, that surgery and therapy would have wiped me out completely."

PROBLEMS ENCOUNTERED

The neighbor added that, although he is a substantial businessman with wide experience in shopping to find the best buy in most commodities and services, he feels helpless in the complex maze of medical services. He found the cost of the surgery itself shocking but not too surprising. But he could not understand why the surgeon at Johns Hopkins kept charging $20 or more for each 2-minute bedside visit (with no apparent services) for days following the surgery. Even more baffling was the $330 charge for anesthesia service for a not too long operation.

If the surgical problem had been of an ordinary nature, it could have been handled very adequately at our fine little hospital in Berkeley Springs. There most of the charges would be less than in a large metropolitan hospital. But the young and highly trained surgeons who operate locally are not satisfied with the fees they get. They see no rational basis for medicare allowing them only $150 for an operation which would be allowed nearly $300 in Winchester, Va., or Hagerstown, Md., both relatively small cities less than 50 miles away.

These two surgeons settled in our rural area two years ago in response to months of recruiting by a committee of community leaders dedicated to overcoming the local doctor shortage. Concerning physicians' reimbursement under medicare and medicaid they feel (a) there is no rational basis for considering "reasonable cost" to be so much lower in rural than in urban communities in this region; (b) those who set the reimbursement rates do not keep abreast of inflationary increases and do not consult local practitioners (therefore, they have few compunctions about charging more than the recognized rates); and (c) they would be glad to participate in a program for working out an agreed fee schedule.

Not one of the six physicians serving this county now accepts assignments under medicare. Inadequacy of the rates is the main reason given. Adjustments to keep up with general inflation are too infrequent they feel. Red tape and reimbursement delays are also deterrents.

Only one of the six physicians regularly accepts medicaid patients. He is not at all satisfied with either the amount or the promptness of payment, but is willing to sacrifice to meet a human need. Local welfare workers worry about what will happen when this elderly general practitioner retires.

This case is indicative of a wide-spread and growing problem. Of West Virginia's 1,922 active medical practitoners in January 1974, over one-fourth were more than 60 years of age. The oldest age group was the general practitioner with a median age of 56. The extreme difficulty of replacing these as they retire underscores the great importance of adequate fees for physicians in rural areas.

THE DILEMMA: ADEQUACY OF FEES VERSUS INFLATION

No means of mitigating these problems without some liberalization of reimbursements in rural areas is apparent to us. Yet that aggrevates inflation and inflation is already extreme in the medical field. According to the latest Consumer Price Index, the rate of increase in physicians' fees reached a high of eight-tenths of a percent in June. In the past year doctors' fees increased 11.6 percent, almost twice as much as the increase in all items (5.9 percent).

One observation worth considering may be that the public is not particularly aware of the disproportionate increase in medical costs; increases in utility bills are much more obvious. According to the Federal Council on Wage and Price Stability, this is because medical costs increases tend to be absorbed by federal programs and private insurance, thus masking the burden which, of course, must ultimately be borne by consumers.

SUGGESTIONS ON FEE SCHEDULING

Whatever revision in the present "reasonable charge" system is worked out, we feel, should give local physicians a greater sense of participation in determining the reimbursement rates for their services. Hopefully, then, they will have greater willingness to accept assignments. Equally, if not more important, consumers should participate in deciding fee schedules and also be enabled to do comparison shopping for physicians' services. They should have the necessary information regardless of whether they pay directly or pay indirectly through insurance premiums or taxes.

One way of facilitating this may be through price posting. West Virginia recently adopted a program for prescription drug price posting. A state agency prepares a list of one hundred most commonly used prescriptions, including the generic equivalent of each brand of drug where available. Then the individual pharmacy enters its current prices and makes the list available for review. This facilitates comparison shopping.

An added feature designed to foster consumer awareness of inflationary trends could be to post alongside the current price a base price formerly charged at some "bench mark" period.

Might not a similar approach be tried for physician and other health services in offices, clinics, and hospitals? The posted list would have four columns (1) the name of typical services, (2) normal charges currently being made at the office or institution, (3) charges considered allowable or reasonable by medicare or other responsible agency and (4) base price formerly recognized by medicare at a "bench mark" period.

Even if posting seems too radical or complicated, advance information or estimates of costs should be more readily obtainable by a patient or his aide.

The idea of a statewide schedule of medicare/medicaid fees, as proposed by H.R. 6699 (Fulton) has considerable appeal. For one thing, it would tend to reduce the reimbursement handicap which rural practioners feel as compared to their urban counterparts. On balance, however, it seems sounder to vary the fees on the basis of medical economic areas rather than having a single statewide schedule.

Another questionable feature of the Bill is its placing responsibility for recommending physicians' fees in the Governor "after consulting . . . medical societies." To adopt this approach would ignore or circumvent the mechanisms for fee determination, etc., which states are establishing under the National Health Planning and Resources Development Act (Public Law 93-641).

COMPREHENSIVE SYSTEMS APPROACH

In keeping with Public Law 93-641 State Health Systems Agencies should be given more adequate support for carrying out their responsibility for comprehensive health planning, including cost containment as well as improvements in the accessibility and quality of health care. Certainly any changes in the reimbursement system under medicare should not inhibit or complicate HSA operations.

What the 200-odd health systems Agencies do should be recognized as preparing the way for a comprehensive, systematic approach to the many-sided yet unified problem which is the subcommittee's concern. That approach will almost inevitably entail universal health insurance sooner or later. Why not sooner? We strongly feel the Health Security Act (H.R. 21-S3) must be enacted soon. Although interim measures such as the Talmage/Duncan Bill (S3205/HR13080) may be necessary, we fervently hope they will not delay real reform in America's present nonsystem of health services.

In conclusion, I will repeat, with slight adaptation, one sentence from the testimony which our Committee Chairman, Rev. Richard Bowyer, offered for your Subcommittee Hearing last August 3rd:

"If and when payment for services are based on careful projections and planned cost controls and allocated on a budget basis, then and only then can we expect to see the rising costs of hospitalization (and other health care) brought into any kind of responsible curtailment."

MEDICARE POLICY RELATING TO REIMBURSEMENT OF PHYSICIANS IN TEACHING HOSPITALS

THURSDAY, SEPTEMBER 16, 1976

House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met at 8:30 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The committee will come to order.

Dr. Hamburg, I appreciate your coming here at this early hour. The House is scheduled to take up as one of the first items of business today the conference report on the tax reform bill, and as a member of the conference committee, I feel an obligation to be present when the House considers this legislation.

I am sorry for any inconvenience the change in the time of this hearing may have caused.

The original medicare law provided very little guidance on the question of how reimbursement should be determined for the services of physicians in teaching hospitals.

Specifically at issue is the question of how reimbursement should be determined for the services of a teaching physician when he supervises interns and residents in the care of hospital patients.

The issues are complex and controversial. How they are decided will not only affect the medicare and medicaid programs, but may well also influence the nature of postgraduate medical education in this country and the financial stability of teaching hospitals.

In legislation enacted in 1973, the Congress called for a study—to be conducted by the National Academy of Sciences—of appropriate and equitable methods of reimbursement for physicians' services in teaching hospitals.

That study has now been completed and the study report has been submitted to us. We will be briefed today on that study by the Institute of Medicine of the National Academy of Sciences.

After that, we will hear comments on the study and the issues involved from representatives of the administration and of the Association of American Medical Colleges.

Although our focus today will be primarily on teaching physician reimbursement, the National Academy of Sciences was asked to include in the study an examination of what influence medicare and medicaid reimbursement may have on the geographical and specialty distribution of physicians, on the participation of foreign medical graduates in certain training programs, and on training programs for interns and residents generally. We have invited the Academy to include information on these subjects in today's briefing.

The Congress has postponed until the fall of 1977 certain provisions of existing law regarding teaching physician reimbursement, in order to have the benefit of the findings and recommendations of the National Academy's study.

I am sure that what we learn today will help us as we determine what the permanent policy should be in this complex reimbursement area.

I would like to include in the record at this point the press release announcing today's hearing, along with a briefing document prepared by the staff, and the executive summary of the study report by the Institute of Medicine, National Academy of Sciences.

[The material referred to follows:]

[Press release of Wednesday, Aug. 4, 1976]

THE HONORABLE DAN ROSTENKOWSKI (D., ILL.), CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCES A ONE-DAY HEARING ON MEDICARE POLICY RELATING TO REIMBURSEMENT OF PHYSICIANS IN TEACHING HOSPITALS, TO BE CONDUCTED THURSDAY, AUGUST 26, 1976[1]

The Honorable Dan Rostenkowski (D., Ill.), Chairman of the Subcommittee on Health of the Committee on Ways and Means announced today that the Subcommittee will hold a one-day hearing on the issues involved in payment of physicians in teaching hospitals under medicare. This hearing will begin at 9:00 a.m. on Thursday, August 26, and will be conducted in B-316 Rayburn House Office Building.

The hearing will examine the findings and recommendations contained in a major study of medicare-medicaid reimbursement in the teaching setting that was conducted at the request of the Congress by the Institute of Medicine of the National Academy of Sciences. The hearing will afford an opportunity to the Subcommittee to be briefed on the study by witnesses from the Institute of Medicine and to receive comments on the study and the issues involved from the Department of Health, Education, and Welfare and from other interested and knowledgeable individuals and organizations.

The Institute of Medicine study was requested by the Congress in the hope that it would provide information that would assist in resolving the serious problems that have existed since the early days of the medicare program in determining appropriate methods of reimbursement for services of teaching physicians. The original medicare law did not address the specific issue of how medicare should determine reimbursement for the services of a physician when he supervises interns and residents in the care of patients. In 1972, the Congress did adopt a specific policy through the enactment of section 227 of Public Law 92-603, but implementation of this policy has been postponed, until October 1977, in order to permit a thorough study to be conducted by the National Academy of Sciences and to allow time for the Congress to give full consideration to the study's findings and recommendations.

Allocation of time to witnesses

In view of the limited time available for this hearing, it will be necessary to allocate the amount of time available to each witness for presentation of his direct oral testimony and this time allocation will be strictly adhered to. The witnesses' full statements, as well as any additional materials they would like to submit, will be included in the record of the hearing.

Cutoff date for requests to be heard

Requests to be heard must be received by the Committee no later than the close of business, Thursday, August 19, 1976. Requests should be addressed to John M. Martin, Jr., Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building Washington, D.C. 20515, telephone (202) 225-3625. Notification of a witness' scheduled appearance will be made as promptly as possible after the cutoff date. If a witness finds that he cannot appear, he may wish to either substitute another spokesman or file a written statement for the record.

---

[1] The hearing was subsequently postponed to Sept. 16, 1976.

Written statement in lieu of personal appearance

Any interested person or organization may, instead of a personal appearance, file a written statement for inclusion in the printed record of the hearing. For this purpose, statements should be submitted in triplicate by the close of business, Thursday, August 26, 1976. Additional copies may be furnished for distribution to members of the Committee, the staff press, and interested public, if submitted to the Committee early on the morning of August 26.

Requests to be heard must contain the following information

1. The name, full address, and capacity in which the witness will appear.
2. A list of persons or organizations the witness represents.
3. A topical outline or summary of the comments and recommendations which the witness proposes to make regarding the reimbursement issues discussed in the Institute of Medicine Study Report (the hearing topic is strictly limited to these issues).

Persons scheduled to appear before the Subcommittee to testify at this hearing must submit 50 copies of their prepared statements to the Committee office no later than 24 hours prior to their scheduled appearance. An additional 50 copies may be furnished for distribution to the press and interested public on the date of appearance.

94th Congress }
2d Session }

COMMITTEE PRINT

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

MEDICARE REIMBURSEMENT FOR SERVICES OF PHYSICIANS IN TEACHING HOSPITALS

SEPTEMBER 9, 1976

Prepared by the staff for use by the Subcommittee on Health, House Committee on Ways and Means, with the assistance of the Congressional Research Service, Library of Congress

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1976 WMCP: 94–147

COMMITTEE ON WAYS AND MEANS

AL ULLMAN, Oregon, *Chairman*

WILBUR D. MILLS, Arkansas
JAMES A. BURKE, Massachusetts
DAN ROSTENKOWSKI, Illinois
PHIL M. LANDRUM, Georgia
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
JAMES C. CORMAN, California
WILLIAM J. GREEN, Pennsylvania
SAM M. GIBBONS, Florida
JOE D. WAGGONNER, JR., Louisiana
JOSEPH E. KARTH, Minnesota
OTIS G. PIKE, New York
RICHARD F. VANDER VEEN, Michigan
J. J. PICKLE, Texas
HENRY HELSTOSKI, New Jersey
CHARLES B. RANGEL, New York
WILLIAM R. COTTER, Connecticut
FORTNEY H. (PETE) STARK, California
JAMES R. JONES, Oklahoma
ANDY JACOBS, JR., Indiana
ABNER J. MIKVA, Illinois
MARTHA KEYS, Kansas
JOSEPH L. FISHER, Virginia
HAROLD FORD, Tennessee

HERMAN T. SCHNEEBELI, Pennsylvania
BARBER B. CONABLE, JR., New York
JOHN J. DUNCAN, Tennessee
DONALD D. CLANCY, Ohio
BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
WILLIAM A. STEIGER, Wisconsin
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
JAMES G. MARTIN, North Carolina
L. A. (SKIP) BAFALIS, Florida
WILLIAM M. KETCHUM, California

JOHN M. MARTIN, Jr., *Chief Counsel*
J. P. BAKER, *Assistant Chief Counsel*
JOHN K. MEAGHER, *Minority Counsel*

Subcommittee on Health

DAN ROSTENKOWSKI, Illinois, *Chairman*

JAMES C. CORMAN, California
OTIS G. PIKE, New York
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
JOE D. WAGGONNER, JR., Louisiana
WILLIAM R. COTTER, Connecticut
MARTHA KEYS, Kansas

JOHN J. DUNCAN, Tennessee
PHILIP M. CRANE, Illinois
JAMES G. MARTIN North Carolina
DONALD D. CLANCY, Ohio

MEDICARE REIMBURSEMENT FOR SERVICES OF PHYSICIANS IN TEACHING HOSPITALS

Introduction

The Social Security Amendments of 1972 contained a provision designed to correct certain deficiencies in medicare relating to payment for the medical care that residents, interns, and supervisory physicians provide in teaching hospitals. The regulations that the Secretary of Health, Education, and Welfare proposed to implement this so-called teaching-physician provision, brought forth expressions of serious concern from the medical education community and, before they could be put in effect, the Congress called on the National Academy of Sciences (NAS) to conduct a thorough study of the issues. The NAS submitted its report to the Congress on March 1, 1976.

The effective date of the 1972 teaching-physician provision has been postponed until October 1, 1977, to give the Congress sufficient time to consider the NAS findings and recommendations and to determine whether the 1972 provision and the regulations proposed by the Department of Health, Education, and Welfare should go into effect. The purpose of this report is to provide pertinent background information for this review and to outline some of the more important problems and issues that have been encountered in devising an equitable method of paying for services of physicians in teaching hospitals.

A. PATIENT CARE IN TEACHING HOSPITALS

1. *The house officers*

Almost all medical school graduates, having earned their M.D. or equivalent degree, continue their education by entering a graduate medical education program in one of the Nation's 1,250 teaching hospitals. The initial period of training is often a 1-year internship. Most interns go on to receive training in one of the 23 medical specialties in a hospital residency program. Teaching hospitals range in character from the large inner-city institutions for indigents, in which most of the medical care is provided by residents and interns, to suburban hospitals with a small teaching program where paying patients are cared for primarily by their personal physician.

The period of internship and residency training, lasting as long as 5 or more years, gives the medical school graduate an opportunity to gain experience by caring for patients in a supervised setting. There were some 55,000 house officers (i.e., residents and interns) in 1975; about one-third were graduates of foreign medical schools.

While the house officers have an M.D. or equivalent degree, usually are licensed, and often render a very substantial volume of medical care, the patients they treat, who are called "teaching patients," are not considered to be their patients. Rather, a specific physician, called a "teaching physician," is responsible for each teaching patient. The house officer is considered a trainee and is paid a salary (e.g., $12,000 per year for a first year resident) by the institution; he is not permitted to bill teaching patients for the services he renders.

In the spring of 1975, NAS surveyed a sample of 81 non-Federal hospitals as part of its congressionally-mandated study. The survey indicates that house officers spend about 85 percent of their time in the hospital providing patient care, usually without the direct supervision of a teaching physician. The degree of responsibility that any particular officer is given for treating patients depends in part on the character of the hospital. In the NAS study, hospitals were classified as "private-patient hospitals" if the great majority of the patients were admitted as private patients by their own physician and as "nonprivate-patient hospitals" where the patients, who were indigent for the most part, looked to the institution to provide them with a physician. Some hospitals were classified as dealing with both types of patients.

House officers were usually responsible for initiating patient treatment in all the nonprivate-patient hospitals. This was also the usual practice in 10 percent of the private-patient hospitals.

In about three-fourths of the nonprivate-patient hospitals, house officers reported that they usually serve as the primary surgeon as compared to about one-third of the private-patient hospitals. House officers gave orders for routine medical treatment and were responsible for routine daily management of patients within an approved treatment plan in both types of hospitals.

The extent to which the house officers' patient care activities are supervised by a teaching physician will generally depend somewhat on whether or not the patients are the teaching physician's private patients. According to the NAS study, a physician was personally present about one-third of the time the house officers were engaged in patient care in private-patient hospitals and about one-quarter of the time in nonprivate-patient hospitals.

It should be noted that the house officers play a number of different roles. In addition to caring for patients with and without physician supervision, they also teach and supervise junior house officers and medical school students; spend time studying; and do research and perform administrative duties.

2. The teaching physician

The supervision and training of house officers is carried out by physicians—called teaching physicians—who have a variety of different kinds of arrangements with the hospital medical education program. These arrangements run the gamut from salaried physicians who are employed full time by the hospital or affiliated medical school to volunteer physicians with a private practice in the community who donate time to a medical education program. Data from the American Medical Association, the Association of Medical Colleges, and the NAS study suggests that from one-fourth to one-third of the Nation's 300,000 physicians are involved in graduate medical education to at least some extent.

Teaching physicians engage in teaching, patient care and research to varying degrees, often carrying out two of these activities—e.g., teaching and patient care—at the same time. The full-time teaching physicians in the NAS study spent, on the average: 20 percent of their time in activities that involved both patient care and teaching; 11 percent of their time in pure teaching; 20 percent of their time in pure patient care; and 15 percent of their time in research. The balance of the time, about one-third of the total, was divided between administrative duties and their own professional development. The part-time teaching physicians spent about the same proportion of their time in joint teaching and patient care activities and in pure teaching. However, they spent less of their time in research (5 percent) and administration and professional development (26 percent) and almost twice as high a proportion of their time (35 percent) in pure patient care.

3. Teaching patients

The relative importance of the roles played by teaching physicians and house officers in the care of a patient usually depends on whether the hospital classifies the patient as a private or nonprivate patient. Traditionally, this classification has been based on the patient's ability to pay for his hospital care. The patient who can pay is usually seen by his physician in the physician's office and the physician arranges for the patient's admission to the hospital as his own private patient. The patient expects to pay the physician and in turn holds the physician personally responsible for his care. If a house officer assists the physician, his role, in most cases, is one of a subordinate.

On the other hand, the patient who cannot pay his hospital bill has traditionally been classified as a nonprivate patient; although assigned to a teaching physician, his care is often rendered almost exclusively by house officers. Traditionally, the private patients have been segregated from nonprivate patients—sometimes they are located in different hospitals and sometimes they are placed in different locations in the same hospital.

The segregation of patients has led to criticisms that two levels (i.e., two qualities) of care are being provided. Also, representatives of the medical education community have expressed the view that house officers acquire a broader educational experience if they deal with a representative patient population that consists of paying patients as well as the indigent. Paying patients can also benefit the teaching institution financially. As a consequence, some teaching hospitals have attempted to attract increasing numbers of paying patients and to mix the private and nonprivate patients together without differentiation. Of the 38 hospitals in the NAS study that had both private and nonprivate patients, 18 mixed the two classes of patients and 20 maintained separate physical settings (e.g., a ward, floor, etc.) for them.

B. MEDICARE AND TEACHING HOSPITALS

1. 1965 legislation

The original 1965 medicare legislation provided for teaching hospitals to be reimbursed for the costs associated with their teaching programs in the same manner as other hospital costs. The committee reports that accompanied the legislation explained that educational activities enhance the quality of care in an institution and that their costs, including the house officers' salaries and the compensation of teachers, should be covered under the hospital insurance program until the community undertakes to bear the costs in some other way. This approach was in line with preexisting Blue Cross practices and the American Hospital Association's reimbursement policy.

The issue of how medicare should reimburse for the services of a teaching physician when he supervises house officers was not specifically addressed by the original legislation. The statute provided two possible methods of paying for these services:

(1) Where the physician is found to have rendered a medical service to the patient, a reasonable charge may be paid under part B of medicare.

(2) When the physician is engaged in administrative activities, teaching of house officers or other services that are primarily for the benefit of the institution rather than a specific patient, no charge is payable. Instead, the hospital can be reimbursed under part A for costs—e.g., salary—it may incur in compensating the physician.

The problem in applying these provisions was, of course, that many of a teaching physician's activities involve elements of both institutional and patient services—e.g., where he teaches a medical procedure to a house officer by supervising him in his performance on a patient. The question of which payment method would be applicable in the various teaching situations was important to teaching institutions since they would benefit financially if they could collect fees for services performed by salaried physicians, volunteer physicians, and house officers.

Shortly before the new medicare program was to go into effect, representatives of medical education and various physician organizations met with social security officials to discuss payments for medical services in teaching hospitals. The consultant group preferred that the program pay charges for medical care rendered by house officers in all cases because teaching physicians are responsible for the actions of the house staff. Such a policy would have produced medicare revenues far in excess of the institutions' costs of treating the program's beneficiaries, and the net income could have been used to finance care for nonpaying patients and to make improvements in the institutions' medical education programs and patient care. It was also pointed out that medicare was enacted to enable the elderly to attain the status of paying patients. However, payment of fees for services rendered by house officers seemed inconsistent with the clear statutory intent that the services of the house officers would be reimbursed on a cost basis under the part A program.

The final regulations followed an alternate approach that was developed in cooperation with the consultant group of permitting teaching hospitals and teaching physicians to charge medicare in a manner similar to independent practitioners where the physician provides personal and identifiable direction to the house officers who care for the patient, including supervision in person in the case of major surgery or other complex or dangerous situations. The intent of these regulations was to allow a charge only where, as a minimum, the teaching physician performs such actions as reviewing the patient's medical records and examining him within a reasonable time after admission, reviewing the house officer's diagnosis and proposed treatment plan and making frequent reviews of the patient's progress.

It proved difficult to achieve effective and uniform application of this policy to the widely varying teaching hospital settings. In some cases, charges were billed to the program and paid for medical services which clearly did not involve any degree of participation by a teaching physician. In some instances, charges were billed for the services of house officers in every case, resulting in substantial overpayments. Also, the medicare policies resulted in payment of fees in situations where no other health benefit program paid fees, or where they paid substantially less than medicare.

In 1969, more detailed program instructions were issued, but the basic policy was left intact. Extensive efforts to review the appropriateness of billings on a hospital-by-hospital basis disclosed additional cases of noncompliance and misunderstanding and lack of acceptance of the requirements of the program.

2. 1972 legislation

General dissatisfaction with medicare reimbursement policies led, in 1972, to legislation that dealt specifically with teaching physicians. The committee reports explained that it was the Congress' intent in enacting the original medicare law that charges paid for a physician's services should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients—that is, if a physician merely took legal responsibility for care, no fee should be paid. Or, if the physician performed the service differently than is usually done when a patient engages his own private physician, the differences should be reflected in the charge paid by medicare. The reports explained:

> There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not by law, be turned over to the house staff: in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focuesd on the relationship between doctor and patients, the services of these physicians should be reimbursed as a hospital cost rather than on a fee-for-service basis under the supplementary medical insurance program.
>
> At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned for the hospital to his care.

The primary objective of the 1972 legislation was to limit fee-based reimbursement to situations involving bona fide private patients. However, past experience has pointed up the problems involved in individually determining the status of each teaching hospital patient. Therefore, the legislation provided for a presumption to be made that all of the inpatients or outpatients of a teaching hospital would be deemed to be private patients for whom medicare fees would be paid if all the patients of that hospital had been regularly billed for physicians' services during 1966 and thereafter, reasonable efforts have been to collect, and at least half the patients paid 75 percent or more of the billed amount.

The committee reports describe the concept of "private patient" in some detail. However, because of the extremely wide variety of teaching programs throughout the country, the law authorized the Secretary of HEW to define "private patient" by regulation. Under the HEW regulations, a hospital that could not meet the above statutory test would be a private-patient institution if: at least 85 percent of its patients were receiving their principal medical services from physicians whom they had seen prior to hospitalization and whom they recognized as their personal physician; a majority of the patients paid 75 percent or more of their physicians' fees in the past year from sources other than public assistance programs; and ability to pay was not a factor in determining what services or accommodations patients receive. This second test could be met on a hospital-wide basis; also, if a wing, floor or other location in a hospital could meet the test, the patients in that unit would be deemed to be private patients.

Teaching patients who are not deemed to be private patients under one of the above tests would be considered to be nonprivate unless, in an individual case, it could be shown that the patient was treated by a personal physician who billed for his services to other patients in the same setting and collected from a majority of them.

The 1972 legislation also liberalized cost reimbursement for the teaching physicians' services for which no medicare fee would previously have been allowed. One of these changes permits payments to be made to a teaching hospital's medical staff in recognition of the services donated by volunteer teaching physicians. These medicare payments may only be used for charitable or educational purposes.

3. Postponement of 1972 legislation

In its comments to HEW on the regulations proposed by the Secretary to define "private patient" for medicare reimbursement purposes, the Association of American Medical Colleges (AAMC) submitted a report which, among other things, assessed the impact of the proposed regulations on six unnamed member medical schools and teaching hospitals. The AAMC argued that the regulations would damage some teaching programs by depriving them of needed income.

The regulations were also criticized on the ground that they would promote a 2-class system of care in hospitals that could meet the fee collection test only by establishing a private-patient unit for their paying patients. While AAMC's data were far too limited to serve as a basis for drawing conclusions about the appropriateness of the proposed regulations, they did raise questions about the impact of the existing and the proposed reimbursement policies that the Congress believed deserved further study.

Accordingly, legislation was enacted in 1973 which directed HEW to arrange for a study, to be conducted by the National Academy of Sciences, of appropriate and equitable methods of reimbursement for physicians' services in teaching hospitals. This and subsequent legislation has postponed the effective date of the 1972 teaching physician amendment until October 1977.

The National Academy of Sciences submitted its final report to the House Committee on Ways and Means, the House Committee on Interstate and Foreign Commerce, the Senate Finance Committee. and HEW officials on March 1, 1976.

C. SOME ISSUES FOR CONSIDERATION

1. How should house officers' salaries and other graduate medical education costs be financed? Through health benefit programs such as medicare, with its relatively regressive form of taxation? Through a general-revenues-financed program that is specifically designed to support specified graduate medical education objectives (e.g., the improvement of the distribution of physicians geographically and by specialty)? If so, how would the education programs that are eligible for reimbursement be identified?

2. Should medicare, in addition to reimbursing an institution for an appropriate share of all costs connected with graduate medical training and its related patient care activities, also pay fees? If so, should the fees be based on services the house officers perform? Should any such fees be based on services the teaching physicians furnish and if so, how would reasonable charges be set for such services as supervision, training, reviewing medical records, etc.? Should the amount of time a physician spends in these activities be a factor in determining the payment?

3. Should medicare pay fees where a "private patient" is involved but not where the patient is "nonprivate"? If so, how should the status of patients be determined? Should medicare pay fees in teaching settings where fees are not paid on behalf of most other patients? Should medicare pay higher fees than are paid for nonmedicare patients?

4. How far should medicare payment policies go in supporting improvements or changes in patient care by, for example, paying amounts in excess of actual costs that can be used by the institution or its medical staff to purchase needed equipment or make other improvements, or to support a single class of care?

INSTITUTE OF MEDICINE

MEDICARE-MEDICAID REIMBURSEMENT POLICIES

Social Security Studies

Final Report

March 1976

SUMMARY AND CONCLUSIONS

Supported by U.S. Department of Health, Education, and
Welfare Contract No. SSA-PMB-74-250

National Academy of Sciences
Washington, D.C.

NOTICE

The project that is the subject of this report was approved by the Governing Board of the National Research Council, whose members are drawn from the Councils of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine. The members of the Committee responsible for the report were chosen for their special competences and with regard for appropriate balance.

This report has been reviewed by a group other than the authors according to procedures approved by a Report Review Committee consisting of members of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of medical and other professions for the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 Congressional charter responsibility to be an advisor to the Federal Government, and its own initiative in identifying issues of medical care, research, and education.

2101 Constitution Avenue, N.W., Washington, D.C. 20418

Area 202 389-6891

IOM Publication 76-01

INSTITUTE OF MEDICINE

Social Security Studies

STEERING COMMITTEE

Chairman

Adam YARMOLINSKY, Ralph Waldo Emerson Professor of the University, University of Massachusetts, Boston, Massachusetts

Members

Robert M. BALL, Scholar-in-Residence, Institute of Medicine, National Academy of Sciences, Washington, D.C.

H. Robert CATHCART, President, Pennsylvania Hospital, Philadelphia, Pennsylvania

Robert A. DERZON, Director, Hospitals and Clinics, University of California at San Francisco

Merlin K. DUVAL, M.D., Vice President for Health Sciences, The University of Arizona, Tucson, Arizona

Maureen HENDERSON, M.D., Assistant Vice President for Health Affairs, University of Washington, Seattle, Washington

John L. S. HOLLOMAN, Jr., M.D., President, New York City Health and Hospitals Corporation, New York, New York

Alvin J. INGRAM, M.D., Chief, The Campbell Clinic, Inc., Memphis, Tennessee

James F. KELLY, Ph.D., Executive Vice Chancellor, State University of New York, Albany, New York

Max MICHAEL, Jr., M.D., Assistant Dean, Jacksonville Hospitals Educational Program, Jacksonville, Florida

Morton D. MILLER, Vice President and Chief Actuary, The Equitable Life Assurance Society of the United States, New York, New York

Robert G. PETERSDORF, M.D., Professor and Chairman, Department of Medicine, University of Washington, Seattle, Washington

Social Security Studies
Steering Committee
(Continued)

Louis ROLNICK, Director, Welfare and Health Benefits Department, International Ladies' Garment Workers' Union, New York, New York

Charles L. SCHULTZE, Ph.D., Senior Fellow, Brookings Institution, Washington, D.C. (resigned June 1975)

J. Jerome WILDGEN, M.D., Physician and Surgeon, Family Medical Association, Inc., Kalispell, Montana

INSTITUTE OF MEDICINE

DAVID A. HAMBURG, M.D., President

Social Security Studies - Staff

Ruth S. Hanft, Study Director

James E. Lewis, Ph.D., Deputy Study Director
Barbara L. Cohen, Special Assistant
Juliana V. Goldberg, Editor

Teaching Hospitals

James E. Lewis, Ph.D., Technical Director
David A. Bowers
Nan E. Cohen
Melissa Craig*
Polly M. Ehrenhaft
Cleo E. Hancock
Karl D. Hermanson
Joshua H. Minkove
David R. Ott
Richard B. Sablowsky*
Betty L. Sheltra
Rebecca B. Smith
Sunny G. Yoder
Jane W. Young

Field Staff*

Miriam Alter
Carl Angelis
Walter J. Chao
Christine Cook
Susan Corcoran
John Criner
Edward Curran
Thomas Flowers
Laurie Goldstein
Harry Hetherington
Miriam Lipman
Catherine McLaughlin
Charles E. Newkirk
Patricia Parker
Hila R. Sherer
Brenda Smith
Gwendolyn M. Taylor

Manpower Analysis

Martha Blaxall, Ph.D., Technical Director
Jon R. Gabel
Barbara S. Heller*
Wanda B. Robinson
Gloria Ruby
Lynn Squire*
Jose Villavicencio*
Catherine C. White

Manpower Modeling

Richard J. Greene, M.D., Ph.D., Technical Director
Kathleen Dolan
Lenard Cohen

Data Resources

Mary G. Brown, Director
Judith L. Barlin
Catherine J. Goeser
Po-Kyung Kim

---

*Assignments completed on or before 12/31/75.

PREFACE

In 1973, congressional concern about the conditions for payment of teaching physicians under Medicare and Medicaid, and the effects of such payments to physicians and teaching hospitals on patient care, graduate medical education, and the distribution of health care services led to legislation calling for a study to be conducted by the National Academy of Sciences. Section 15c of the Social Security Amendments of that year states that:

> The Secretary of Health, Education, and Welfare shall arrange for the conduct of a study or studies concerning (A) appropriate and equitable methods of reimbursement for physicians' services under Titles XVIII and XIX of the Social Security Act in hospitals which have a teaching program approved as specified in section 1861 (b) (6) of such Act, (B) the extent to which funds expended under such titles are supporting the training of medical specialties which are in excess supply, (C) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty, (D) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates, and (E) the existing and appropriate role that part of such funds which are expended to meet in whole or in part the cost of salaries of interns and residents in teaching programs approved as specified in section 1861 (b) (6) of such Act.

The specific origin of this legislation was problems with the methods used for the payment of physicians in teaching hospitals, as expressed in charge (A). The rest of the charges reflect concern about several broader health manpower issues.

A steering committee of the Institute of Medicine, National Academy of Sciences, was appointed to provide policy guidance and direction to the study staff; the recommendations are the recommendations of the steering committee. Three advisory panels were established to provide technical assistance in the areas of teaching physicians and teaching hospitals, specialty and geographic distribution, and foreign medical graduates.

The data were gathered and analyzed by the staff of the Institute of Medicine.

INTERPRETATION OF THE CHARGE

The questions raised in the congressional charge are related to broader issues such as the financing and organization of health care and graduate medical education. In the recommendations, however, the steering committee has responded to the specifics of the congressional charge and remained as neutral as possible on the broader issues.

We have tried to make our recommendations on the choice between fee-for-service and cost options consistent with latitude for institutions to employ payment modes of their own choice, while minimizing the problems of payment that the Congress identified. We also wished to encourage experimentation with new modes of payment.

We have based our recommendations for reimbursement of costs associated with teaching or learning on the existing general framework for support of graduate medical education in the United States, recognizing that fundamental changes in that framework (for example, direct support for graduate medical education through capitation grants) might make some of our recommendations unnecessary and others inappropriate. And we have framed our analysis and our single recommendation on foreign medical graduates without making any assumptions as to the adequacy of the future supply of United States medical graduates or the quality of foreign medical graduate training.

ORGANIZATION OF THE REPORT

The report is in three parts:

- Part I is a summary of the study findings and the responses to the specific charges of Congress.

- Part II presents detailed findings; analysis of data collected in the study, including description of the graduate medical education programs in teaching hospitals; discussion of the methods of analyzing different ways to pay physicians who teach and provide patient care services;

effects of different methods of payment on institutions; factors affecting geographic and specialty distribution; determination of optimal physician supply; federal policies to effect improved distribution of physicians; and foreign medical graduates in graduate medical education programs.

- Part III contains technical appendices on the study methods (to be published in May 1976).

Chapter 1 of Part I of the report summarizes the findings, conclusions, and recommendations of the study on the payment of physicians in teaching hospitals. Options for payment of physicians in teaching hospitals are discussed with recommendations for future payment methods. Detailed data gathered in the field studies of 96 hospitals and data from the Institute of Medicine's National Survey Questionnaire, sent to 1,400 hospitals, provide the basis for the findings. A consistent method was developed to test the effect of the options analyzed and to be used in defining additional options. Chapters 1 through 6 of Part II contain detailed descriptions of institutional organization and financing of teaching hospitals and medical schools, teaching physician activities and compensation, organization of patient care in teaching hospitals, graduate medical education, discussion of the role of carriers and intermediaries, and an analysis of the impact of different payment options.

Chapter 2, Part I analyzes the influence Medicare and Medicaid payments may have on the geographic and specialty distribution of physicians. To respond to these charges, it was necessary to explore the potential methods and problems of determining "optimal" supply of physicians by specialty. Seminars were conducted for four states - Arizona, Oregon, Michigan, and Georgia - to determine the possibility of defining optimal specialty distribution. Participants were given information on demographic characteristics of the area, available health indicators, utilization data, national and international physician distribution information, and whatever physician productivity data were available. They explored the availability and usefulness of data in determining optimal distribution and made suggestions for methods of determining these distributions in the future.

The study group also analyzed economic and social factors that affect the concentration and distribution of physicians in the United States. Data from the field studies and National Survey Questionnaire provided the basis for the analyses of sources of support of training programs. A study of Medicare, Medicaid, and private insurance fees was undertaken to determine what relationships, if any, exist between fees and distribution of physicians. Chapter 2 of Part I summarizes the findings on specialty and geographic distribution; detailed analyses are in Chapters 7 through 10 of Part II.

Data were gathered and analyzed on the distribution and activities of foreign medical graduates in graduate medical training programs, and Medicare and Medicaid support of these programs. Chapter 3 of Part I summarizes these findings, discussed in detail in Chapter 11 of Part II.

NATIONAL SURVEY

A questionnaire survey of the nation's 1,400 identifiable teaching hospitals brought a response from 73 percent of them. Information was collected on characteristics, finances, and educational programs in teaching hospitals. It included patient payment status, number of house staff, support of house staff salaries, number of foreign medical graduates in training, medical staff sources of compensation and teaching activities, and contractual arrangements for physician services.

FIELD STUDIES

Site visits were made to 96 teaching hospitals, 15 of which were federal Veterans Administration hospitals; 15 medical schools; and two osteopathic schools, in addition to pretests in three medical schools and seven teaching hospitals. The field studies provided information about institutional organization and financing; house officer activities and support of graduate medical education programs; teaching physician activities and relationships with patients; billing and collecting arrangements; and compensation and employment agreements between physicians and the medical school or hospital. Field staff examined the organization and delivery of patient care, including admission into patient services; assignment of patients to physicians and patient care settings within the hospitals; patient payment status; systems used for billing patients and third party payors; and systems used for collection and distribution of revenues from patient care fees.

INTERMEDIARY AND CARRIER SURVEY

All intermediaries and carriers who administer Parts A and B of Medicare were surveyed for their definitions of teaching physicians and teaching hospitals, their interpretation of the Social Security Administration's current instructions concerning the reimbursement of teaching physicians, Intermediary Letter 372 (IL 372), and the frequency and methods of audit. Follow-up visits were made to a sample of carriers.

FEE SCREEN SURVEYS

The Social Security Administration (SSA) has developed data on prevailing fee screens for 39 procedures for all Medicare carriers. The Institute of Medicine, in cooperation with SSA, the Office of the Assistant Secretary of Planning and Evaluation, and the Medical Services Administration of the Social and Rehabilitation Services, collected similar data from most state Medicaid agencies. The Health Insurance Association of America made available its information about level of surgical fees paid by the major carriers within regions. Fee data were not available from the Blue Shield plans.

SUMMARY

Ever since the implementation of the Medicare program in 1966, there have been problems with its methods of payment for physician services in teaching hospitals. The Medicare payment structure is based on the long-standing model of separate billing by the hospital and the patient's physician. Medicare Part A, the hospital insurance program, pays hospital costs, including salaries of interns and residents, and supervising physicians participating in education programs in the hospital. Medicare Part B, the supplementary medical insurance program, pays for the services of the physician who is responsible for the care and medical decisions concerning any particular patient.

In teaching hospitals, the actual services and responsibilities do not correspond to the crisp distinctions implied by Part A and Part B. Teaching and patient care occur inseparably. Responsibility for the patient, medically if not legally, becomes shared among the teachers and the learners. The complexity of dividing payment between Part A and Part B for these indivisible services has been of mounting concern to the Congress, medical educators, and the Social Security Administration, which administers Medicare.

Several efforts have been made to ease the situation, but with only limited success. Instructions have been issued in an attempt to clarify the circumstances under which a teaching physician may be paid for personal and identifiable professional services to patients or for the supervision of such services when provided by interns and residents. The current policy is embodied in Intermediary Letter 372, promulgated in 1969.

An amendment to the Social Security law (Section 227) was enacted in 1972 in an effort to simplify the payment problem by establishing presumptions that, if met, would result in many hospitals being classified in their entirety as (1) hospitals in which the physician or hospital could bill for professional fees and (2) those that must be paid on a cost basis for professional services. The classification scheme entailed a professional test and a patient liability test. In other situations, Section 227

allowed physicians to bill on a fee basis for services to patients with whom they had a prior professional relationship. But before Section 227 was implemented, the Social Security Amendments of the following year, 1973, requested that this Institute of Medicine study be made of the Medicare payment system for physician services in teaching hospitals. Pending completion of the study, Section 227 was suspended.

The charges for this study, as stated verbatim in the preface, are concerned principally with determining appropriate and equitable methods by which Medicare and Medicaid can pay for physician services in teaching hospitals. However, Congress also asked for an examination of how the payments affect the distribution of physicians both by specialty and geographically, and how they attract foreign medical graduates to one type of training program or another.

In an effort to answer the principal congressional question, the Institute of Medicine study group sent a national survey questionnaire to the 1,400 identifiable teaching hospitals in the United States and conducted detailed field investigations of 96 teaching hospitals, 81 of them non-federal. The survey and field studies were designed to collect the most complete possible array of facts on teaching physicians, teaching hospitals, their variety of patients, their relationships with medical schools, the revenues created by teaching and patient care, and the various controls and uses for those revenues. These and more data were needed before the study group could consider the effects of present Medicare payment methods and anticipate what might be accomplished by making changes in those methods.

Capsule descriptions of the information gathered on teaching hospitals, and the study group's recommendations based on analysis of that information, immediately follow. After those will be found similar summary sections, each with recommendations, on specialty and geographic distribution of physicians, and on foreign medical graduates. A more detailed explanation of the findings and recommendations is contained in the body of the report.

TEACHING HOSPITALS

The teaching physician provides graduate medical education and patient care in the teaching hospital. Lacking a definition from legislative history or regulations, the study defines a teaching physician as a fully trained physician (therefore, not enrolled in a graduate training program) who is responsible for or directly engaged in patient care activities and is responsible for the instruction and supervision of interns, residents, or fellows.

The close interweave of education, research, and patient care in teaching hospitals means that teaching physicians spend much of their time in joint activities, most commonly teaching in conjunction with patient care, which occupies 20 percent of total professional time of salaried hospital physicians. The principal student in joint teaching and patient care is the house officer (intern, resident, or fellow), more than 80 percent of whose time is spent in activities directly related to patient care.

A great variety of compensation arrangements exists between teaching physicians and hospitals or medical schools. Many teaching physicians are employees of the institutions. Others have contracts that stipulate specific services or amounts of time. Teaching physicians often have financial arrangements with more than one institution. ontrol of professional fee revenues ranges from solely institutional, in which case physicians are on salary or contract, to solely practitioner-run, in which case the physician bills and collects, and has no financial arrangement with the hospital. In between those extremes are faculty practice plans that receive and control fees at the level of the medical school, department, or hospital. Where they can be identified, professional fees make up 9.7 percent of gross revenue of public medical schools and 12.4 percent of gross revenue of private schools. Most of these fees are applied to faculty compensation.

House staff compensation, with few exceptions, is by salary from the hospital, medical school, or both. In the majority of hospitals studied, house officer salaries came from general patient care revenues. In some other instances, salaries came from state or local appropriations to the institutions.

The 96 federal and non-federal hospitals in the field study sample were classified in one of four ways according to their education ties with medical schools: (1) principal teaching hospitals, 32 of the sample, are those in which medical school clinical departments direct all aspects of graduate training programs; (2) graduate associated hospitals, 44 of the sample, have one or more training programs directed by medical school clinical departments, and may also have training programs independent of the medical school; (3) undergraduate associated hospitals, 10 of the sample, have a tie to a school only for undergraduate clinical training, and conduct their own independent graduate medical education programs; (4) independent hospitals, 10 of the sample, conduct only their own graduate medical education programs.

The type of hospital ownership--voluntary nonprofit, government, or proprietary--has a relationship to the type of patient population. To some extent, patients classify themselves by their choice of hospitals. Medicaid patients, by definition medically indigent, more often choose public hospitals. Medicare patients, whose shared quality is age or disability rather than indigency, more often go to voluntary nonprofit and proprietary hospitals.

Patients also are classified by the hospitals, usually on admission, according to a prior client relationship with the attending physician or their ability to pay. Their classification as "private" or "non-private" patients has a relationship to the profile of the hospital overall. Among the 81 non-federal hospitals of the sample, 23 had a patient population classified almost entirely as private; 20 others had almost all non-private, and 38 had proportions of both.

Hospitals with mostly private patients (1) were all voluntary nonprofit or proprietary, (2) without exception used fee-based methods of payment for physician services, (3) had physicians in control of professional revenues in 78 percent of the instances, and (4) included four principal teaching and three independent hospitals, the entire group having minimal involvement in graduate education--a median of five programs per hospital.

The 20 hospitals with mostly non-private patients (1) included 19 publicly owned, (2) included 11 that used a cost-based or compensation related method of payment for physician services, (3) had nine others that used fee-based methods but only six of those with physician control of professional revenues, and (4) included 10 principal, nine associated, and one independent teaching hospital--with a median of eight graduate programs per hospital.

The 38 hospitals with both private and non-private patients (1) included 29 of nonprofit-voluntary ownership, (2) had 35 using fee-based payment of physicians, (3) had physician control of professional revenues in 21 of those 35 instances, and (4) included 11 principal, 21 associated, and six independent teaching hospitals--with a median of 12 graduate medical education programs per hospital.

Patient classification also is a factor in the extent of a house officer's responsibility for patient care and the amount of supervision the house officer receives. House officers have more responsibility and less supervision by teaching physicians when they are taking care of non-private patients than they do with private patients.

The study group examined six existing or potential methods by which Medicare might pay for physician services in teaching hospitals. The methods are:

- conventional fee, the same system that applies to non-teaching physicians
- IL 372, the present policy used in determining eligibility of a teaching physician for a Medicare fee payment
- Section 227 "fee," the proposed stricter definitions of circumstances under which a fee could be paid to a teaching physician for services to patients

- Section 227 "cost," an option under which a teaching hospital may choose to receive cost reimbursement for teaching services
- unified payment, which would pay charges under Part B of Medicare for all physician services whether they were performed by a teaching physician or a house officer. Supervision by teaching physicians and house officer salaries would no longer be paid as part of hospital costs
- lump sum payment, a negotiated amount paid for specified services to a specified group of beneficiaries.

Each payment method was evaluated for its responsiveness to the congressional charges and its potential effects on teaching physician compensation and activities, institutional organization and financial support, graduate medical education, patient care, and program costs. The analysis indicated that no one payment method would constitute appropriate and equitable compensation in all teaching hospital circumstances, or could be applied universally without adverse effects on graduate medical education in the United States.

RECOMMENDATIONS (abridged)*

The steering committee has developed recommendations that recognize congressional concerns about appropriate and equitable payment of teaching physicians for professional services in teaching hospitals....Two recommended payment methods--a cost method and a unified method of payment--fully answer the concerns of Congress about proper payment for the type of care received. At the present time, however, neither fits the way in which graduate medical education is conducted in most institutions. It has been necessary, therefore, also to recommend incremental improvements in the more generally applicable method of fee payments to teaching physicians under Part B and cost-based payments for interns and residents under Part A. ...The steering committee believes that, for cost and unified payment methods to be fully effective, other third party payors would have to adopt them.

Recommendation 1. A Cost-Based Method of Payment*

The elective cost reimbursement payment method currently in effect under Section 15, Public Law 93-233 should be continued. Minor modifications are recommended...:

---

*See detailed recommendations in Chapter 1.

(1) Fee-based payment should be allowed in hospitals electing cost for special care units...that are open to the community.

(2) The cost of physician services should reflect as closely as possible the full costs of providing the services.

(3) Under the cost payment regulations issued under Section 15, Public Law 93-233, inclusion of payment of the imputed value of volunteer services should be continued....

(4) Under the same cost regulations...The ceiling of $30,000 on the imputed value of a volunteer teaching physician's services should be changed to the average salary for full-time physicians in the area or the VA compensation for full-time physicians if an area average is unavailable....

Recommendation 2. A Unified Method of Payment*

The unified method of payment is appropriate to institutions where there is a physician team approach to patient care and graduate medical education. Present knowledge and understanding of this method of payment suggest that it is responsive to the concerns of Congress and also appropriate to the ideals of graduate medical education. All services of licensed physicians (teaching physician and house officer) are paid out of Part B, except house officers who have not completed the first year of post-M.D./D.O. training (or second depending on state licensure requirements). Such house officers would be paid on a cost reimbursement basis to the hospital. The proposed conditions for this payment method limit its application to teaching institutions where there is a close relationship between teaching physician and house officer so that the conditions for personal and identifiable service are met by the team regardless of who actually performs the service....

Recommendation 3. A Fee-Based Method of Payment*

A fee-based method payment is appropriate for teaching physicians only when they provide personal and identifiable services to program beneficiaries or directly supervise the provision of such services by house officers....With one exception, the physician role test as described in the proposed Section 227 regulation is deemed appropriate as a test of whether personal and identifiable services are provided. The exception is the requirement for a preadmission relationship between the physician and patient....Under this method, after two years, no cost reimbursement would be allowed for supervisory and teaching services in teaching hospitals....

---

*See detailed recommendations in Chapter 1.

Recommendation 4. Demonstration and Experimental Payment Methods

Three payment methods are recommended for demonstration and experiment in the Medicare and Medicaid programs. Each proposal for a demonstration or experimental payment method should include a plan for evaluating the payment method which includes its effects on the program beneficiary, the physician, the institutional provider, and the program itself:

(1) The unified method of payment (Recommendation 3) with less restrictive conditions and criteria as may be proposed by physician groups or institutions and agreed to by the Social Security Administration on a demonstration and experimental basis.

(2) The lump sum method used widely to provide payment for professional patient care services to specific patient groups, for example, crippled children under Title V, Maternal and Child Health Programs. This method of payment involves a negotiated contractual relationship between physicians or institutional providers and the payor....

(3) A fee-based method under which licensed residents in family practice, general practice, pediatrics, and general internal medicine who have completed either the first year of post-M.D./D.O. training (or second year, depending on state licensure requirements) would be certified by the director of the training program as qualified to perform independently certain specified services or procedures in the hospital outpatient department. The resident could be paid for these services just as any fully trained physician would be....There would be no cost reimbursement for salaries of these residents and no consultant fee paid for teaching.

Recommendation 5

Section 227 of Public Law 92-603 should not go into effect on July 1, 1976. Until new legislation can be enacted and attendant regulations issued, Section 227 of Public Law 92-603 should be further suspended and authority to continue cost reimbursement for physician services under Section 15, Public Law 93-233 should be extended.

Recommendation 6*

Administrative priority should be given to getting a more uniform application of the Medicare regulations and guidelines across the country....

---

*See detailed recommendations in Chapter 1.

Recommendation 7

To move toward more uniform treatment across programs, the recommended payment methods for teaching physicians should be given serious consideration by state Medicaid programs and other third party payors.

Recommendation 8

Proposals for future changes in the method of payment should be accompanied by "impact analyses," which would estimate the dollar differences to result from the change, the effects on the structure for receipt and control of professional service revenues, and the effects on the beneficiary, institutional provider and professional, and the health insurance program.

DISTRIBUTION OF PHYSICIANS BY SPECIALTY AND GEOGRAPHY

Congress asked about the extent to which Medicare and Medicaid payments support the training of medical specialists "in excess supply" and how the payments could be used to encourage a more rational distribution of physicians both by specialty and geographically.

There are great problems in trying to define what might be an appropriate supply of physicians among the various specialties or among all the communities of the nation. There is little agreement on the "needs" of a population for health care services. There is imperfect understanding of relationships among physician distribution and other components of the health care system, including its organization and financing.

The study group conducted a series of seminars to collect the judgments of experts as they experimented with methods of determining the optimal distribution of generalist and specialist physicians for several states of the United States. The results of those manpower seminars, together with a review of comparative data from other studies and an analysis of the compatibility of numbers of residency positions with present and future physician manpower goals, led the study group to some conclusions about the distribution of physicians and the influences toward one or another medical specialty, or one or another location in the country.

- Primary care appears generally to be undersupplied, and would benefit from an increase in the total number and proportion of "contact" physicians.

- Surgery appears to be oversupplied and should have no further increase in ratio of surgical specialists to population, which in effect, means limiting the number of physicians entering surgical specialty training.

- There exist identifiable geographic regions of contact physician shortage, which would benefit from increases in number of contact physicians and innovations in extending their services.

- A physician's choice of specialty is not adequately explained by expectation of lifetime earnings, is not made at any one particular time in the education process, is frequently changed, and is predisposed toward examples that the education process presents--greater specialization, less ambulatory care.

- Medicare and Medicaid payments support faculty and house officer salaries in teaching hospitals, and would seem to favor the present pattern of the education process--greater specialization--over the establishment of new training -- ambulatory care -- because of less favorable reimbursement provisions for outpatient care.

An analysis was undertaken of Medicare and Medicaid fees in relation to physician choice of location or specialty. Medicare and Medicaid payments accounted for 17 percent of payments to physicians in the United States in 1973. In general, it was found that prevailing charges and therefore, the general pattern of physicians' fees, tend to be higher in areas with high physician-to-population ratios. Other factors with which high Medicare fees are associated are concentration of hospital beds and medical schools, high income areas, large metropolitan areas, and West Coast counties.

RECOMMENDATIONS (abridged)*

Recommendation 1

The steering committee recommends that financing mechanisms be changed to provide more equitable support for ambulatory care services so that medical school and teaching hospitals would find it easier financially to support primary care training programs. Furthermore, Medicare and Medicaid monies might be used as an incentive to support the expansion of training opportunities in the contact physician specialties. The costs of residencies in the contact physician specialties should be excluded from provisions of Section 223 which place a ceiling on the allowed increase on costs to be covered by Medicare.

Recommendation 2

The steering committee recommends that direct support to medical schools and teaching hospitals through special project grants for the support of primary care training be continued.

Recommendation 3

A permanent quasi-public independent physician manpower commission of 13 members should be established by law to monitor the specialty distribution of physicians to determine the appropriate number of residency slots for each specialty. The enforcement of the commission's determinations would be the responsibility of the Liaison Committee for Graduate Medical Education, the Coordinating Council on Medical Education, and the American Osteopathic Association Committee on Postdoctoral Training through extension of their respective accreditation mechanisms, to control the number of residency positions in each training program....If, after appropriate consultation with the private sector, the Secretary of HEW finds that the commission's determinations have not been implemented within three years following the establishment of the commission, the Secretary should seek legislation to reconstitute the commission as a federal advisory committee to himself and to permit the withholding of Medicare and Medicaid funds from residency programs in specialties considered in excess supply by the commission.

---

*See detailed recommendations in Chapter 2.

Recommendation 4

The steering committee recommends that the following interim strategy for postgraduate physician training be implemented on July 1, 1977, and remain in force until the commission and the voluntary accreditation agencies have time to develop and implement a comprehensive physician manpower plan.

(1) With the exception of the category of contact physicians, defined as family practice, general internal medicine, and general pediatrics, the number of all other postgraduate specialty training slots available as of July 1, 1977, should be held at the level of residency positions filled as of July 1, 1975.

(2) The number of training slots for contact physicians should be expanded, with care given to ensure that the highest quality education environment is maintained.

(3) There may be unusual circumstances which warrant an expansion of residency training slots in other than the contact specialties. Examples of these situations would include medical schools in the process of development or pending commitments to individual trainees.

Recommendation 5

A major study should be undertaken to re-examine the basis of physician fees and fee allowances in public and private health insurance programs.

Recommendation 6

The study group recommends that Medicaid practices which pay physicians at lower levels [in one geographic area than in another], particularly in underserved areas, be discontinued.

Recommendation 7

A detailed examination of Medicaid administrative practices should be undertaken to document the extent to which these practices affect the availability of physician services in underserved areas.

FOREIGN MEDICAL GRADUATES

The congressional charge for this study also asked for a determination of the extent to which Medicare and Medicaid payments "support or encourage training programs which tend to disproportionately attract foreign medical graduates."

United States medical education, and particularly its graduate programs, has had a steadily increasing influx of foreign-trained participants since the 1948 Smith-Mundt Act, which authorized exchange visas for citizens of other countries who wished to pursue educational opportunities here. In 1950, hardly 10 percent of the United States internships and residencies were occupied by foreign medical graduates. By 1975, one-third of the house officers in American teaching hospitals were foreign-trained and about one-fifth of all licensed physicians in the country were foreign graduates. During that 25-year period, the number of graduate training positions increased faster than the number of United States medical students who would fill them, while further changes in the exchange visitor education program and immigration laws made entry of foreign physicians easier than ever before.

The availability of approved graduate training positions to foreign medical graduates in the future, however, is expected to decline. Government incentives during the 1960s for an increase in American physician supply prompted an increase in the number and size of United States medical school classes. Projected numbers of the United States graduates indicate that by the mid-1980s they will fill almost all the currently existing graduate education slots. And the present total of slots may be greater than in the mid-1980s; the preceding recommendations of this report alone, as concerns a moratorium and monitoring for most categories of graduate medical education, pose a possible reduction in the number of approved programs. Lessened opportunities for foreign-trained physicians to enter graduate medical programs here also will reduce their eventual numbers in the fully licensed United States health system; most licensing bodies here require completion of graduate programs by foreign-trained physicians.

Although an overall diminution of opportunities for foreign medical graduates in the United States is readily discernible, an identification of programs that "disproportionately attract" them is a more complex undertaking and entails normative judgments. The study group examined the characteristics of programs and institutions to determine their positions relative to national averages of foreign medical graduate concentrations. For the purposes of this study, these guidelines were established:

- A particular specialty is considered above the national average if the proportion of foreign medical graduates in training exceeds the proportion of foreign medical graduates in training in all specialties.
- A particular training program is considered above the national average if the percentage of foreign medical graduates exceeds the national average for that specialty.
- An institution is considered above the national average if more than 30 percent of its house staff are foreign medical graduates or if more than 38 percent of its training programs have foreign medical graduate percentages that exceed the national specialty average.

Categories of hospitals with the greatest concentration of foreign medical graduates above the national average were: state independent (69 percent), private independent (61 percent), local independent (60 percent), and private undergraduate associated and state undergraduate associated (both 59 percent).

In general, the more closely a hospital is affiliated with a medical school the less likely it is to have an above-average concentration of foreign medical graduates. Only 40 percent of the principal and graduate associated institutions have a foreign medical graduate concentration that exceeds the national average; 56 percent of undergraduate affiliated institutions and 60 percent of independent institutions have above-average concentrations.

Medicare and Medicaid support was not greatly different for institutions of high and low concentrations of foreign medical graduates. Information collected from United States medical graduates and foreign medical graduates in house officer positions indicates that to some extent the foreign-trained physicians occupy slots remaining after United States-trained physicians have made their graduate education choices.

RECOMMENDATION

In view of the decreasing number of positions likely to be available for foreign medical graduates and the possibility that future foreign medical graduates may not be able to get the graduate medical education necessary for full licensure in this country, the steering committee recommends the elimination of existing incentives for physician immigration, including the removal of medicine as a shortage profession under the Department of Labor's Schedule A.

Mr. ROSTENKOWSKI. Good morning, Doctor, and welcome to the committee. As I said earlier the inclement weather and early hour certainly didn't deter us and we appreciate the fact that you made it to be with us this morning.

Please identify yourself and your colleagues, Dr. Hamburg, and begin your testimony. We will be pleased to receive it.

STATEMENT OF DAVID A. HAMBURG, M.D., PRESIDENT, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, ACCOMPANIED BY PROF. ADAM YARMOLINSKY, ROBERT BALL, AND ROBERT DERZON, MEMBERS, INSTITUTE OF MEDICINE STUDY REPORT STEERING COMMITTEE, AND RUTH HANFT, STUDY STAFF DIRECTOR

Dr. HAMBURG. Thank you, Mr. Chairman.

The inclement weather detained two of my colleagues who will be along.

Mr. Chairman, I am David Hamburg, President of the Institute of Medicine of the National Academy of Sciences. I am pleased to be here to testify on a study that the Institute of Medicine recently conducted at your request.

I would like to provide an overview of our study report, which was sent to you March 1. Then I invite you to raise any questions you wish with the five of us who will be here from the Institute of Medicine, especially those who know the study best.

They are: Prof. Adam Yarmolinsky, who headed the steering committee for the study; Mr. Robert Ball and Mr. Robert Derzon, both members of that committee, and Mrs. Ruth Hanft, staff director for the study. Mrs. Hanft and Mr. Ball have not arrived yet.

I would like to express my gratitude to them for the prodigious effort they made in conducting this study.

INTRODUCTION

The studies reported in the Institute publication entitled "Medicare-Medicaid Reimbursement Policies," were requested by Congress in the Social Security Amendments of 1973. Section 15c of those amendments asked, in essence, that studies be conducted to determine:

1. Appropriate and equitable ways to pay for services of physicians in teaching hospitals for services to medicare and medicaid patients.
2. The extent to which such payments support training in medical specialties that are "in excess supply."
3. How the payments might be used to improve the distribution of physicians both geographically and by specialty.
4. Whether the payments support or encourage teaching programs that "disproportionately attract" foreign medical graduates.
5. The way in which such payments support the salaries of interns and residents in teaching hospitals.

The principal and specific reason behind the congressional charges for these studies is the difficulty experienced in making appropriate and equitable Federal reimbursement for physicians services in the teaching hospitals. The rest of the charges reflect concern about several broader health manpower issues.

Ever since the implementation of the medicare program in 1966, there have been problems with its methods of payment for physician services in teaching hospitals. The medicare payment structure is based on the longstanding model of separate billing by the hospital and the patient's physician.

Medicare part A, the hospital insurance program, pays hospital costs, including salaries of interns and residents, and supervising physicians participating in educational programs in the hospital. Medicare part B, the supplementary medical insurance program, pays for the care and medical decisions concerning any particular patient.

In teaching hospitals, the actual services and the responsibilities do not correspond to the crisp distinctions implied by part A and part B. This is a point I would like to emphasize, teaching and patient care occur inseparably in such hospitals. Responsibility for the patient, medically if not legally, becomes shared among the teachers and the learners. The complexity of dividing payment between part A and part B for these indivisible services has been of mounting concern to the Congress, medical educators, and the Social Security Administration.

Several efforts have been made to ease the situation, but with only limited success. The current policy is embodied in intermediary letter 372, promulgateed in 1969, modified by the 1973 amendment which permits cost reimbursement. That statement attempts to clarify the circumstances under which a teaching physician may be paid for personal and identifiable professional services to patients, or for the supervision of such services when provided by interns and residents.

But the difficulty of making those distinctions led to concerns about reimbursement abuses. A General Accounting Office study in 1970 found considerable confusion on the part of teaching physicians and institutions as to the circumstances in which fee payment was appropriate. That study report concluded that there had been overpayments, duplicate payments, and other abuses. These concerns were summarized in the Senate report accompanying the 1972 social security amendments.

One of those 1972 amendments was designed to clear up the ambiguities of payment to teaching physicians. It added a section 227 to the Social Security Act. Section 227 would have replaced the provisions of the intermediary letter 372. When the proposed regulations concerning section 227 were published, they caused such deep concern among some medical organizations that Congress postponed implementation of section 227 until this, this Institute of Medicine study was completed. Since then section 227 has been further postponed to provide time for enactment of new legislation. That additional postponement was one of the recommendations of this study report.

The proposed regulations for section 227 would have allowed teaching physicians to charge on a fee-for-service basis only for services they performed for "private patients."

Two tests were established to define "private patients" for an entire hospital or particular setting within the hospital. If either test could be met, all the patients in that hospital or that setting would be considered "private" patients. The medical community, however, regarded both tests as difficult to administer by many of the large teaching hospitals. If neither test could be met, the proposed regulations offered two other tests for the definition of "private" patients on a patient-by-patient basis. Both of those tests had to be met and they posed a much stricter definition of doctor-patient relationship than required heretofore.

Section 227 would have permitted one other option, an alternative to fee-for-service payment for professional services in teaching hospitals. That option provided the opportunity, if all physicians with admitting privileges in a hospital agreed, for the hospital to function on a cost basis for professional services with respect to medicare and medicaid. Salaries and related support costs of physician services would be paid under part A for services to medicare patients; no individual physician charges for such services would be permitted. The last option became available through the Social Security Amendments of 1973. By the beginning of this year, 27 teaching hospitals had chosen payment on a cost basis.

To examine the issue of appropriate ways to pay physicians in teaching hospitals, the Institute of Medicine study group sent a national survey questionnaire to the 1,250 identifiable teaching hospitals in the United States and conducted detailed field investigations in 17 medical or osteopathic schools and 96 teaching hospitals.

The survey and field studies were designed to collect a broad array of facts on teaching physicians, teaching hospitals, their variety of patients, their relationships with medical schools, patient care revenues, and the uses for those revenues. These and more data were needed before the study group could consider the effects of present medicare payment methods and anticipate what might be accomplished by making changes in those methods.

I would like very briefly to describe the information gathered on teaching hospitals, and the study group's recommendations based on analysis of that information. After that will come summaries and recommendations on specialty and geographic distribution of physicians, and on foreign medical graduates all briefly stated.

TEACHING HOSPITALS

The teaching physician provides graduate medical education and patient care in the teaching hospital. Lacking a definition from legislative history or regulations, the study defines a teaching physician as a fully trained physician, one who is responsible for or directly engaged in patient care activities and is responsible for the instruction and supervision of interns, residents, or fellows.

The close interweave of education, research, and patient care in teaching hospitals means that teaching physicians spend much of their time in joint activities, most commonly teaching, in conjunction with patient care which occupies 20 percent of total professional time of salaried hospital physicians. (Table 1.)

The principal student in joint teaching and patient care is the house officer—intern, resident, or fellow—more than 80 percent of whose time is spent in activities directly related to patient care.

I want to emphasize that more than 80 percent of the house officers' time is spent directly related to patient care.

The 96 hospitals in the field study sample were classified according to a number of different characteristics in order to determine possible relationships among the characteristics. The closeness of a hospital's education tie to a medical school was sorted into four categories, ranging from principal teaching hospitals of medical schools in which medical school clinical departments direct all aspects of graduate training programs, to independent hospitals, which conduct only their own graduate medical education programs. (See tables 2 and 3.)

Patient population in teaching hospitals was classified into mostly private, mostly nonprivate, or a mixture of both. Patients classify themselves, to some extent, by their choice of hospitals. Medicaid patients, by definition medically indigent, more often choose public hospitals. Medicare patients, whose shared quality is age or disability rather than indigency. more often go to voluntary nonprofit and proprietary hospitals. Patients sometimes are classified by the hospitals, usually on admission, according to their prior client relationship with the attending physician, or their ability to pay or both.

Their classification as private or nonprivate has a relationship to other characteristics of the hospital (table 4). Of the 81 non-Federal hospitals in the sample, 23 had almost all private patients, 20 others had almost all nonprivate, and 38 had proportions of both.

Hospitals also were classified according to ownership—voluntary nonprofit, proprietary, or government. In a moment I will try to pull some of these characteristics together, along with some variables on the ways teaching physicians are paid.

A great variety of compensation arrangements exists between teaching physicians and hospitals or medical schools. Many teaching physicians are employees of the institutions. Others have contracts that stipulate specific services or amounts of time. Teaching physicians often have financial arrangements with more than one institution. Control of professional fee revenues ranges from solely institutional, in which case physicians are on salary or contract, to solely practitioner run, in which case the physician bills and collects fees and has no financial arrangement with the hospital. In between those extremes are faculty practices plans that receive and control fees at the level of the medical school, at the level of the department within the medical school, or by the hospital (table 5). Where they can be identified in the sample institutions, professional fees make up nearly 10 percent of the gross revenue of public medical schools and more than 12 percent of gross revenue of private schools.

Most teaching physicians receive their income from a combination of professional earnings and institutional funds. When the physician controls his own fees, the institution with which he is associated usually does not know his total income, but only the portion, if any, paid from institutional funds. Most institutions and practice plans also do not know the payor sources of fee revenues; for the few that record this information, medicare and medicaid together account for 30 percent.

Faculty physicians in the 17 sample medical schools generated at least $60.7 million in fees in fiscal 1974. More than half of the fees were used to support the physicians who generated them; the rest supported general institutional expenses such as travel, support staff, and equipment.

Professional fees provide a substantial source of support for most medical school faculties. In some, support is direct because funds flow through institutional accounts. Even if fees go directly to physicians, they indirectly support the institutional programs if those physicians teach and care for patients at little or no cost to the institution.

House staff compensation, with few exceptions, is by salary from the hospital, medical school, or both. In the majority of hospitals studied, house officer salaries came from general patient care revenues. In some other instances, salaries came from State or local appropriations to the institutions.

Some of the characteristics by which the hospitals were classified can be put together as follows:

The 23 hospitals with mostly private patients were all voluntary nonprofit or proprietary, used only fee-based methods of payment for physician services, had physicians in control of professional revenues in 78 percent of the instances, and had a median of only five graduate-education programs per hospital, a minimal involvement in graduate work.

The 20 hospitals with mostly nonprivate patients included 19 publicly owned, included 11 that used a cost-based or compensation-related method of payment for physician services, had 9 others that used fee-based methods but only 6 of those with physician control of professional revenues, and they had a median of 8 graduate programs per hospital.

The 38 hospitals with both private and nonprivate patients included 29 of voluntary nonprofit ownership, had 35 using fee-based payment of physicians, had physician control of professional revenues in 21 of those 35 instances, and had a median of 12 graduate medical education programs per hospital.

Patient classification also is a factor in the extent of a house officer's responsibility for patient care and the amount of supervision the house officer receives. House officers have more responsibility and lease supervision by teaching physicians when they are taking care of nonprivate patients than they do with private patients (table 6).

The study group examined six existing or potential methods by which medicare might pay for physician services in the teaching hospitals. The methods are:

1. Conventional fee, the same system that applies to nonteaching physicians.
2. Intermediary letter 372, the present policy.
3. Section 227 fee, the proposed stricter definitions of circumstances under which a fee could be paid to a teaching physician.
4. Section 227 cost, the option under which a teaching hospital may choose to receive cost reimbursement for teaching services.
5. Unified payment, which would pay charges under part B of medicare for all physician services whether they were performed by a teaching physician or a house officer; supervision by teaching physicians and house officer salaries would then no longer be paid as part of hospital costs.
6. Lump sum payment, a negotiated amount paid for specified services to a specified group of beneficiaries.

Each payment method was evaluated for its responsiveness to the congressional charges and its potential effects on teaching physician compensation and activities, institutional organization and financial support, graduate medical education, patient care, and program costs.

The analysis indicated that no one payment method would constitute appropriate and equitable compensation for all teaching hospital circumstances, or could be applied universally without adverse effects on teaching hospitals and graduate medical education in the United States (see tables 8, 9, and 10).

The major recommendations of the steering committee on the payment of teaching physicians are:

1. Section 227 fee should continue to be suspended until Congress can evaluate the study and enact new legislation. Public Law 94–368, enacted in July 1976, extended the suspension of section 227 until October 1, 1977.
2. The elective cost-based method of payment authorized under the 1973 Social Security Amendments, section 15 of Public Law 93–233, should be continued with modifications.
3. A fee-based method of payment is appropriate for teaching physicians only when they provide personal and identifiable services to program beneficiaries or directly supervise the provision of such services by house officers. With one exception, the physician role test as described in the proposed section 227 regulation is deemed appropriate as a test of whether personal and identifiable services are provided. The exception is the requirement for a preadmission relationship between the physician and patient. Under this method, after 2 years, no cost reimbursement would be allowed for supervisory and teaching services in teaching hospitals.
4. A unified method of payment is appropriate in institutions where there is a physician team approach to patient care. Strict criteria for use of this approach are proposed.
5. Demonstrations and experiments are proposed including the unified method with less restrictive conditions, lump-sum methods, and for fees for provision of services by primary care residents.

SPECIALTY AND GEOGRAPHIC DISTRIBUTION

There are a number of problems in trying to define the appropriate supply of physician manpower. Determining a reasonable distribution of physicians according to specialty and geography is a complex process. Research methods and the data base are in the early stages of development.

Ideally, physician manpower needs should be determined from epidemiological data on needs of the population. But there is no agreement on needs; and epidemiological need does not take into account the caring functions of health manpower, i.e., influences not reflected in measures of mortality or gross morbidity.

Physician distribution is also dependent on other components of the health care delivery system. For example, the use of paraprofessionals may change the requirement for one specialty or another. A highly regionalized medical care system with clear lines of referral may require fewer physicians than a less well organized system. More information is needed on manpower substitution, practice patterns, and productivity of physicians.

Value judgments also enter these determinations. Many Americans seek out specialists rather than generalists, even though the problem may not require a specialist.

Financing of health care services also influences use of services. If people cannot pay for certain kinds of care, merely altering the distribution of it would not improve health services. And then comes the problem that there is no simple relationship between the amount of services generated by the health care system and the health status of the population. Above a certain level, additional resources for medical care may not improve health status, which also depends on nutrition, environment and the like.

Findings and conclusions of the study group on specialty and geographic distribution are based on modeling seminars, literature reviews on determinants of specialty and geographic distribution, our data gathered during the field study and the National Survey of Teaching Hospitals, and the judgments of the steering committee. The following findings relate to the influence of medicare and medicaid reimbursement.

Primary care appears generally to be undersupplied, and would benefit from an increase in the total number and proportion of so-called contact physicians.

Surgery appears to be oversupplied and should have no further increase in ratio of surgical specialists to population; in effect, that means limiting the number of physicians entering surgical specialty training.

A physician's choice of specialty is not adequately explained by expectation of lifetime earnings, is not made at any one particular time in the education process, and is frequently changed.

Medicare and medicaid payments support faculty and house officer salaries in teaching hospitals, and would seem to favor the present emphasis of the education process, that is, greater specialization, over the establishment of new training, ambulatory care, because of less favorable reimbursement provisions for outpatient care. The steering committee concluded that the strategic point of intervention is the control of numbers of residents by specialty.

The steering committee recommended that a permanent quasi-public independent physician manpower commission of 13 members, more than half public, be established by law to monitor the specialty distribution of physicans and to determine the appropriate number of residency slots for each specialty. The enforcement of the commission's determinations would be the responsibility of the Liaison Committee for Graduate Medical Education, the Coordinating Council on Medical Education, and the American Osteopathic Association Committee on Post-doctoral Training. This body would presumably assign slots to specific programs within the overall numbers determined by the advisory committee.

If, after appropriate consultation with the private sector, the Secretary of HEW finds that the commission's determinations have not been implemented within 3 years following its establishment, the Secretary should seek legislation to reconstitute the commission as a Federal advisory committee to himself and to permit the withholding of medicare and medicaid funds from residency programs in specialties considered in excess supply by the commission.

The following interim strategy for postgraduate physician training should be implemented on July 1, 1977, and remain in force until the commission and the voluntary accreditation agencies have time to develop and implement a comprehensive physician manpower plan.

1. With the exception of the category of contact physicians—defined as family practice, general internal medicine and general pediatrics—the number of all other postgraduate specialty training slots available as of July 1, 1977 should be held at the level of residency positions filled as of July 1, 1975.

2. The number of training slots for contact physicians should be expanded, with care given to insure that the highest quality education environment is maintained.

THE INFLUENCES OF THIRD-PARTY PAYMENTS

Third-party payments indirectly support a considerable amount of undergraduate and directly support graduate clinical instruction because they support house officer salaries and supervisory time of attending physicians, and they provide fees to attending physicians who provide joint teaching and patient care with medical students and residents. Under existing reporting systems, it is not possible to separate these payments into individual training programs within a particular hospital; therefore, it is not possible to respond directly to that part of the congressional charge, unfortunately.

It is possible, however, to comment on certain medicare practices that tend to favor some specialties over others in revenues generated by the attending physicians, costs recovered for outpatient services, and ultimately, in resources available for graduate training programs. For example, physicians in the contact specialties, who deliver a larger proportion of their care in the outpatient setting, are more likely to collect none of, or less than, the full charge for the services provided.

On the hospital side, the major disincentive derives from the fact that medicare will pay only 80 percent of the costs of operating an outpatient department.

The study group recommended that financing mechanisms be changed to provide more equitable support for ambulatory care services so that medical schools and teaching hospitals would find it easier financially to support primary care training programs. Furthermore, medicare and medicaid moneys might be used as an incentive to support the expansion of training opportunities in the contact physician specialties. The costs of residencies in the contact physician specialties should be excluded from provisions of section 223 which place a ceiling on the allowed increase in costs to be covered by medicare.

THIRD-PARTY PAYMENTS AND THE PRACTICING PHYSICIAN

Medicare and medicaid payments averaged only about 17 percent of all personal health care expenditures in fiscal year 1973. Structural changes in these programs alone can play only a small part in influencing specialty choice through financial incentives. Nevertheless, more generous coverage of ambulatory services by public and private health insurance programs might serve as an incentive for physicians to elect the contact specialties. To encourage this trend, the study group recommended that all third-party payors incorporate the following principles:

1. Benefit structures, including deductibles and coinsurance, should not encourage the use of inpatient care at the expense of ambulatory care.
2. Fees should be restructured to encourage the delivery of primary care services. Fees earned by contact physicians for the delivery of primary care should be equal to the fees earned by specialists for the same services.
3. In order not to discourage primary care physicians from accepting medicare and medicaid beneficiaries, the allowed charges for them should be comparable to those of other third-party payors.

An analysis was undertaken of medicare and medicaid fees in relation to physician choice of location and of specialty. In general, it was found that prevailing charges and therefore the general pattern of physicians' fees, tend to be higher in areas with high physician-to-patient-population ratios. Other factors with which high medicare fees are associated are concentration of hospital beds and medical schools, high income areas, large metropolitan areas, and west coast counties.

In addition, the structure of physician payment mechanisms must be examined to determine whether there are inequities by specialties and type of service in the way physicians are paid by third-party payors, including medicare and medicaid. There is some evidence that the relative value scales currently in use may affect physician income and productivity by specialty; and, therefore, may implicitly encourage or deter physiicans from entering certain specialties or providing certain services.

The steering committee recommends a major study should be undertaken to reexamine the basis of physician fees and fee allowances in public and private health insurance programs.

FOREIGN MEDICAL GRADUATES

The congressional charge for this study also asked for a determination of the extent to which medicare and medicaid payments "support or encourage training programs which tend to disproportionately attract foreign medical graduates."

U.S. medical education, and particularly its graduate programs, has had a steadily increasing influx of foreign-trained participants since the 1948 Smith-Mundt Act, which authorized exchange visas for citizens of other countries who wished to pursue educational opportunities here. In 1950, hardly 10 percent of the U.S. internships and residencies were occupied by foreign medical graduates. By 1975, one-third of the house officers in American teaching hospitals were foreign-trained and about one-fifth of all licensed physicians in the country were foreign graduates. During that 25-year period, the number of graduate training positions increased faster than the number of U.S. medical students who would fill them, while further changes in the exchange visitor education program and immigration laws made entry of foreign physicians easier than ever before.

The availability of approved graduate training positions to foreign medical graduates in the future, however, is expected to decline.

Government incentives during the 1960's for an increase in American physician supply prompted an increase in the number and size of U.S. medical school classes. Projected numbers of the U.S. graduates indicate that by the mid-1980's they will fill almost all the currently existing graduate education slots, provided that the slots are controlled as proposed in this study.

Although an overall diminution of opportunities for foreign medical graduates in the United States is readily discernible, an identification of programs that "disproportionately attract" them is a more complex undertaking and entails normative judgments. The study group examined the characteristics of programs and institutions to determine their positions relative to national averages of foreign graduate concentrations. In general the more closely a hospital is affiliated with a medical school the less likely it is to have an above-average concentration of foreign medical graduates.

Medicare and medicaid support was not greatly different for institutions of high and low concentrations of foreign medical students. Information collected from U.S. medical graduates and foreign medical graduates in house officer positions indicates that to some extent the foreign-trained physicians occupy slots remaining after U.S.-trained physicians have made their graduate education choices.

Mr. Chairman, members of the committee, that constitutes a very abbreviated description of a study whose principal report occupied more than 400 pages. Again, I invite your questions, and I would like to direct them to one or another of the persons accompanying me who have studied all of these matters in depth and can provide the highest degree of accuracy that is possible in light of present knowledge.

Mrs. Hanft and Mr. Ball who I introduced before are now here and I thank you for consideration of these matters so important to the health of our Nation.

[Attachments to the prepared statement follow:]

TABLE 1.—STAFF PHYSICIANS AND TEACHING PHYSICIANS IN SAMPLE HOSPITALS (1975)

Hospital type	Total staff physicians	Staff physicians who are teaching physicians	Percent of teaching physicians
All	24,948	15,082	60
Principal	11,913	9,061	76
Associated	10,132	4,999	49
Independent	2,903	1,022	35

Note: Since physicians may be staff or teaching physicians at several hospitals, some physicians may be counted more than once.

Source: Institute of Medicine National Survey Questionnaire and field data.

TABLE 2.—CLASSIFICATION OF THE SAMPLE HOSPITALS

Ownership	Total	Principal	Graduate associated	Undergraduate associated	Independent
Total	96	32	44	10	10
Private	53	[1] 9	24	[2] 10	[3] 10
State	13	[4] 13	0	0	0
Local	15	4	11	0	0
Federal	15	6	9	0	0

[1] Includes 5 university-owned hospitals, 1 of which is osteopathic.
[2] Includes 5 osteopathic hospitals.
[3] Includes 1 osteopathic hospital.
[4] Includes 9 university-owned hospitals.

Source: Institute of Medicine field data.

TABLE 3.—DISTRIBUTION OF SAMPLE HOSPITALS BY SELECTED CHARACTERISTICS

Characteristics	Total	Principal	Graduate associated	Undergraduate associated	Independent
Total hospitals	96	32	44	10	10
Region:					
Northeast	14	2	4		8
Mid-Atlantic	28	10	12	4	2
Midwest	20	6	10	4	
South	13	7	5	1	
Southwest	9	2	6	1	
West	12	5	7		
Number beds:					
Less than 150	9	5	2	1	1
151 to 300	22	4	8	5	5
301 to 450	24	6	14	1	3
451 to 600	16	4	10	1	1
More than 600	25	13	10	2	
Number programs:					
Less than 5	30	6	16	4	4
6 to 10	21	4	10	2	5
11 to 20	35	12	18	4	1
More than 20	10	10			
Number house officers:					
Less than 50	44	8	21	7	8
51 to 100	20	9	10		1
101 to 200	16	2	11	2	1
201 to 400	9	7	2		
More than 400	7	6		1	
Occupancy rate:					
Less than 50 percent	1	1			
51 to 70	15	3	11	1	
71 to 80	30	15	14	1	
81 to 90	42	12	17	6	7
More than 90	8	1	2	2	3
Number admissions:					
Less than 1,000	40	13	14	5	8
10,001 to 15,000	27	7	18	1	1
15,001 to 20,000	7	1	3	2	1
20,001 to 30,000	15	5	8	2	
More than 30,000	7	6	1		

Source: Institute of Medicine field data.

TABLE 4.—DISTRIBUTION OF HOSPITALS BY PATIENT CARE TYPE, OWNERSHIP, AND EDUCATION ASSOCIATION (1975)

Hospital classification	Total	Type I, private patients	Type II, nonprivate patients	Type III, private and nonprivate patients
Total	81	23	20	38
State principal	13	0	6	7
Local principal	4	0	4	0
Local graduate associated	11	0	9	2
Private principal	9	4	0	5
Private graduate associated	24	8	0	16
Private undergraduate associated	10	8	0	2
Private independent	10	3	1	6

Source: Institute of Medicine field data.

TABLE 5.—SAMPLE INSTITUTIONS WITH PRACTICE PLANS (1975)

	Total	Public	Private
Medical schools [1]	20	11	9
With plans	15	9	6
Without plans	5	2	3
Hospitals [2]	89	31	58
With plans [3]	10	6	4
Without plans	79	25	54

[1] Includes 2 public and 1 private pretest schools.

[2] Excludes VA hospitals; includes 8 pretest hospitals.

[3] Excludes 17 hospitals covered in all or in part by medical school practice plans and 5 hospitals in which all professional fees go to the hospital.

Source: Institute of Medicine field data.

TABLE 6.—PERCENT DISTRIBUTION OF HOUSE OFFICER TIME

Activities	Total	Principal	Graduate associated	Undergraduate associated	Independent
Total	100	100	100	100	100
Patient care total	67	64	70	73	71
Patient care with direct supervision	29	28	32	31	34
Patient care without direct supervision	38	36	38	42	37
Teaching with patient care	17	18	17	14	15
Learning	10	10	8	10	10
Teaching	2	3	2	1	2
Research	3	4	2	1	1
Administration	1	1	1	1	1

Source: Institute of Medicine field data.

TABLE 7.—SUPERVISION OF HOUSE OFFICERS (PERCENT TIME SPENT IN PATIENT CARE)

Supervision	Type I, private patients	Type III, private and nonprivate patients			Type II, nonprivate patient
		Private settings	Mixed settings	Nonprivate settings	
Total	100	100	100	100	100
Attending physician present	32	15	32	19	23
Senior house officer present	11	13	11	14	17
Independent, review expected	45	51	44	51	47
Independent, no review expected	8	17	9	12	10
Data unavailable	4	4	4	4	3

Source: Institute of Medicine house officer activity analysis.

TABLE 8.—SOURCES OF REVENUES IN SAMPLE HOSPITALS (FISCAL YEAR 1974) (PERCENT)

Source of revenue	Principal			Graduate associated		Undergraduate association, private	Independent, private
	State	Local	Private	Local	Private		
Total revenues	100	100	100	100	100	100	100
Patient care	65	74	88	63	88	87	90
Medicare	14	16	22	15	29	26	25
Medicaid	14	23	13	24	8	15	18
Other payors	37	35	53	25	50	47	48
State or local government appropriations	30	26	0	30	1	1	(1)
Medical school transfers	(1)	0	1	(1)	(1)	(1)	0
Gifts, investments, and endowments	1	(2)	4	1	7	5	3
Other [2]	4	(2)	6	6	4	7	7

[1] Less then 0.5 percent.
[2] Includes revenues from research grants, government contracts, and auxiliary enterprises.

Note: Figures are based on patient care charges before adjustments for such items as bad debts and discounts to staff The majority of hospitals did not allocate adjustments among payors. Excluded are VA hospitals which are funded wholly by the Federal Government and children's hospitals which receive medicare reimbursement for renal dialysis unit costs only. Totals may not add to 100 percent due to rounding.

Source: Institute of Medicine field data.

TABLE 9.—ESTIMATED MEDICARE COST REIMBURSEMENT FOR PHYSICIAN PROFESSIONAL SERVICES AND POTENTIAL REVENUES UNDER FEE-FOR-SERVICE PAYMENT, FISCAL YEAR 1974, HOSPITALS ON COST

	Estimated cost reimbursement for physician services, title 18	Potential revenues under fee-for-service payment	Percentage change in revenues
Hospital:			
A5	$384,000	$595,000	+65
D4	65,000	104,000	+61
D5	21,000	146,000	+600
B2	362,000	239,000	−34
G3	658,000	590,000	−10
AA [1]	17,000	278,000	+1,543
S5	376,000	345,000	−8

[1] This hospital has 2 departments; 1 department currently bills fee for service; the above computations apply only to the cost department.

Source: Institute of Medicine field data.

TABLE 10.—MEDICARE FEE REVENUES AND ESTIMATED REVENUES UNDER 2 COST COMPUTATIONS, MEDICAL SCHOOL PLANS, FISCAL YEAR 1974

	Medicare fee revenues		Cost computation 1 [1]		Cost computation 2 [1]	
	Amount (thousands)	Percent total fee revenues	Estimated revenues (thousands)	Estimated percent change in revenues	Estimated revenues (thousands)	Estimated percent change in revenues
School:						
A (A1)	$948	12	$825	−13	$1,235	+30
B (B1, B6)	864	20	595	−31	897	+4
C (C1)	821	14	471	−43	942	+15
J (J1, J3) [2]	[3] 1,727	20	1,227	−30	2,455	+42
N (N1)	557	10	593	+6	890	+60
P (P1)	777	14	1,009	+30	1,514	+95

[1] Cost computation 1 covers physician salary and fringe benefit (15 percent) costs only; cost computation 2 in addition includes other costs in support of patient care. See text for more detailed description of computation.
[2] J has departmental practice plans; all other institutions have schoolwide practice plans.
[3] Estimate.

Note: Dollar amounts rounded to nearest $1,000; percentages rounded to nearest percent.

Source: Institute of Medicine field data.

Mr. Rostenkowski. Thank you, Doctor. I want to welcome all of you to this meeting. It is not often we get such expertise as we have today at the table, and we look forward to an interesting discussion.

I can see the depth of the study and want to congratulate you all on an excellent presentation and a very thorough job. I remember several years ago in my State there was an issue at Cook County Hospital where fees were inappropriately being paid to a "not-for-profit" organization, which was composed of teaching physicians.

With your study, do you see any possibility of a recurrence of this situation where I believe they had a "not-for-profit" organization where they were charging fees for visiting patients in a public hospital?

Do you remember that, Commissioner?

Mr. Ball. Yes, I do, Mr. Chairman. I remember it very unpleasantly, as a matter of fact.

Actually, of course, that should not have occurred under the regulations as they were at that time. The real ripoff, if you will, was that the physicians were not performing specific services for the patients in any way that was documented and yet were collecting fees for such services.

Following investigation, the instructions and the rules were considerably clarified and tightened up.

Now, if you were to adopt the provisions and the recommendations of this study, they would be further tightened.

There is a list of things that are the same as in section 227—which, as you know, has never been in effect—which the IOM study recommends be adopted as a test of whether personal identifiable services are being performed.

I don't think anyone can guarantee that there might not be a violation of regulation, but assuming complete and good administration of the provision, it would be less likely than it was earlier.

Mr. Rostenkowski. I believe most of us would agree that medicare should pay fees in teaching hospitals with mostly private patients where the nonmedicare and nonmedicaid patient also pays fees.

The controversy of the past several years centered around the hospitals with large numbers of nonprivate patients where physician fees are not paid in most cases.

The 1972 legislation took the position that, where you have these nonpaying, nonprivate patients, medicare should pay the hospital the full cost of the medicare patient's care, including the program share of the salary costs of physician in residence, and salary related to payments for the physicians who donate their services.

Why do you believe that medicare should pay fees in these situations where the nonmedicare patients receiving the same care do not?

Mr. Ball. Mr. Chairman, I don't think we would agree with that characterization of our conclusion. The recommendation of the report is for a very strict and detailed test of when an individual has received personal identifiable services as a basis for paying for those services on a fee basis.

If that test is met, it would ordinarily be in hospitals where this type of service was being performed for others, but in the rare case where only a few were receiving such services, nevertheless, if it were a personal identifiable service by a personal physician of this individual, the committee felt there was no reason why the physician should not be reimbursed on the same basis as a physician in another hospital.

Now, by and large, there are only two possible approaches under our recommendation.

One is that the physician is paid on a fee basis, on a very strict identifiable personal service approach. The other is that all of the physicians in the hospital have to agree to go on a cost basis.

Those are really the only two alternatives. By and large where there are not a large number of people receiving personal identifiable service it would obviously be in the interests of the physicians for the hospital to go on a cost basis, or the physician wouldn't get paid at all.

Mr. Rostenkowski. Well, it seems to me if a teaching physician could collect fees from medicare for services performed by the residents and interns he supervises, he would generate far more medicare income for his efforts than the typical private practitioner.

Don't you think such a physician would be substantially overpaid as far as his services to medicare patients are concerned?

Mr. Derzon. I would like to respond. The study shows teaching physicians don't spend all of their time taking care of patients but spend time on a great many other activities.

Indeed, the role of house staff, whether private patients or service patients, is approximately the same, so the study papers show.

So, in fact, there is no reason to believe that teaching hospital physicians would receive substantially more income from any public program than from any other third party.

Mr. Rostenkowski. You are saying, Doctor, that the fees that he charges are on the same level whether paid for by the private or medicare patient?

Mr. Derzon. I don't think so, but I would have to ask Mrs. Hanft if our detailed studies got into that depth. I don't believe so.

Mrs. Hanft. They didn't. However, we found in a number of areas the teaching physicians were paid by and large by a carrier at a rate lower for the same service than a non-teaching physician.

This is not universal across the country but it does indeed occur in many, many areas. They are not paid on the same fee levels to start with, in some areas.

Tracing individual fees, individual patients, was almost impossible in this study. So we don't have data like this but have from interviews of the carriers, teaching physicians, administrators in the medical schools, some evidence that there are fee differentials between the teaching and nonteaching physician with the teaching physician receiving lower amounts for the same service.

Mr. Rostenkowski. Mr. Duncan.

Mr. Duncan. Along that line, could you tell us why the cost per diem of a patient in a teaching hospital is so much greater than it is in the other hospitals?

Mrs. Hanft. That is very complicated. The Rand Corp. has just conducted a study in New Mexico of medicare and medicare patients which show the reverse, that the total costs including the physicians' fees in the New Mexico situation was higher in the nonteaching than the teaching setting, if you took the full diagnosis.

That study I believe is now being funded by HEW in other places and perhaps the Office of Research and Statistics of the SSA could give you some more detailed information on that subject.

Mr. Duncan. I think the records are available now that you might get an isolated case in New Mexico or Mexico, or wherever it was, but the history of medical care in teaching hospitals, the cost to the Government is so much higher than it is in nonteaching hospitals and that goes to the Veterans' Administration, for example, at Vanderbilt or the University of Iowa—their cost is almost double what it would be at another hospital that they operate.

In fact, the Veterans' Administration receives perhaps more complaints about the service in a teaching hospital than they do in the hospitals they operate outside of the teaching hospital area, because it seems that the service or the professional service is delegated to a student or someone else and they don't get the service.

I know in my own office we get more, and I am from Tennessee, we get more complaints from the Vanderbilt VA Hospital than we do the Mountain Home, which is connected with teaching hospitals, for which the cost is about double.

Mr. Derzon. As a teaching hospital administrator, I feel constrained to say something about that.

I don't want to discuss it from the VA vantage point because I have no personal knowledge.

Mr. Duncan. Yes. I just wanted to comment on that aspect of what the Government is running into.

Mr. Derzon. I would like to talk about a typical State university hospital of which I am a director, and tell you there are cost differentials in teaching hospitals versus nonteaching hospitals.

Some of it is related to the direct costs of postgraduate education. It may be in the general range of 5 or 10 percent of the total hospital costs, maybe not that high in some places.

There is a service return and the studies at this institute show there are definite patient care payoffs for those costs that occur.

I think the most single telling point about most teaching hospitals is they are referal centers for our most complicated care and if you and I look at figures for average cost per diem, we see rather high costs.

It cost us close to $300 a day to take care of a very sick infant and a lot more money to take care of sick children than sick middle-aged people.

These teaching hospitals have high concentrations of very difficult patient care problems and it is a very good use of teaching hospitals to use them to take care of patients that can't be taken care of in other hospitals.

Our problem in the teaching hospitals is that we don't have good data to show differentials in case mix.

I think the No. 1 problem for teaching hospitals of America is to try to get good data on it. I think it will show conclusively that what teaching hospitals do is give good return and are not expensive for what they do.

Mr. Rostenkowski. Mr. Cotter.

Mr. Cotter. Thank you, Mr. Chairman.

I was wondering if the group has made any estimate of the cost going on a fee basis rather than on a cost basis to the Government.

Is there any difference?

If you were to go on a fee basis rather than a cost reimbursement is what I refer to.

Mrs. HANFT. For the total program?

Mr. COTTER. Yes.

Mrs. HANFT. We didn't estimate total program costs. We do, however, show in the document and there are several tables that indicate what would happen in a number of hospitals in the study, the individual hospitals, if they moved from a cost to a fee or a fee to a cost basis.

We found that in general, if you made a very rough estimate, if some of the hospitals that are now on fee switched to cost, there would actually be a small net additional cost to the Federal Government.

Mr. COTTER. What do you mean "small net addition"?

Mrs. HANFT. Two percent.

Mr. COTTER. Two percent.

What is that in dollars?

Mrs. HANFT. In dollars I don't have it, but I can submit it for the record.

Mr. COTTER. You know, it strikes me about this: How do you police or administer a program such as this?

Here you have someone studying to be a doctor, administering services and so forth. How do you divide the time to administer and police it to make sure the Government is not being taken?

This bothers me. The allocation of time is really what I am talking about.

Mrs. HANFT. Well, the allocation of time is very difficult because so much of it happens simultaneously.

Mr. COTTER. That's exactly right.

Mrs. HANFT. But you can't except on an arbitrary basis, say, if you have a joint teaching and patient care activity we will give *x* percent to teaching and *x* to patient care.

It will vary by specialty because the process of teaching and care differs with different specialties, such as psychiatry and surgery.

They are almost inseparable and it is one of the real problems in the teaching hospital setting.

Mr. COTTER. This disturbs me. You could have an instructor giving patient care but at the same time teaching an intern.

How do you allocate the time and protect the Government from being "had"?

Mr. BALL. Mr. Cotter, there are listed in the proposed regulations for 227 a series of things that the physician has to do in order to be eligible for a fee for a specific service and the IOM report adopts those with one exception. I might read a few of the things the teaching physician would have to do to qualify for a fee.

Mr. COTTER. Yes. Well, I can understand that, but still I think it is almost arbitrary.

Mr. BALL. Well, I think there are pretty good tests that both Social Security and Congress worked out in the 1972 amendment.

There are pretty good criteria of what would be a personal physician. He has to review the patient's history and the records of examination and the tests and make frequent reviews of the patient's progress.

He has to document in the record that he has done these things. He has to confirm a diagnosis and determine the course of treatment. He has to personally examine the patient on admission and see the patient regularly thereafter during the stay.

He has to do it and document it. He has to supervise a treatment provided by interns, residents or others to assure it is appropriate and he has to be present and ready to perform any services performed by a personal physician in a nonteaching setting when a major surgical procedure or complex, dangerous medical procedure is performed. He has to be ready to take over and do it.

He must be recognized by the patient as his personal physician and be the person responsible for continuity of the patient's care. He must be looked to by the patient to provide arrangements for any needed followup or postoperative care.

Mr. COTTER. I can see a potential for grave abuse.

Mr. BALL. If these things are present, I would feel quite comfortable that a situation existed where it was perfectly proper to pay a fee. The difficulty in administration is to be sure that these things have happened in the particular case.

They are required to document this in the record. It has to be available for audit and review. My clear impression, and also my understanding from the field work in this study, is that there has been great improvement in this area as compared, certainly, with the early days of medicare where frequently—even if some of these things had been performed—the facts were not well documented.

Mr. COTTER. Look, I am not opposed to this; I still have an open mind.

Mr. BALL. Yes.

Mr. COTTER. You can see these problems. Let me ask you this: If we go on a fee basis does the teaching institution retain the moneys or does the doctor or intern?

Who gets the money, the doctor or the institution?

Mr. BALL. I have forgotten the figures but I think we found that about half the amount went to support the physician himself.

Mrs. HANFT. I think he is asking where do the funds flow. By and large in the institutions we studied the bulk of them the funds flow directly to the individual physician.

Then there are various kinds of practice plans.

Mr. COTTER. Then the doctor is reimbursed, really?

Mrs. HANFT. The doctor is reimbursed, not in all cases. In some cases the money goes into a department fund and in some cases to the hospital and in some cases it goes to a medical school plan.

Mr. COTTER. How do you make this distinction as to whom, whether it goes to a doctor or whoever?

Mrs. HANFT. If there is an agreement between the teaching physician and institution, it is an agreement that he and the institution come to. The arrangements vary from the individual physician collecting the fee to the hospital as a whole collecting the fee, to the medical school.

It is a voluntary agreement between the institution and the physician.

Mr. COTTER. But the institution is really going to dictate?

Mrs. HANFT. Not by and large in most of the hospitals that we studied. It is the physician in most of the instances who is controlling the flow of funds.

Mr. COTTER. Let's take a hypothetical. Supposing there is agreement where the institution and not the individual doctor will be reimbursed, here you may have the interns, low-paid residents, or whatever you term them, performing services and getting reimbursed under part B.

Mrs. HANFT. No. Only if the teaching physician or attending physician provides the personal identifiable services.

Mr. COTTER. OK.

Mrs. HANFT. As services are defined, fees are generated—the interns and residents are paid, but paid out of part A the hospital costs and it comes out of the cost reimbursements formula and it is not on a per-service basis, but on the basis of their salary and fringe benefits.

Mr. BALL. Mr. Cotter you are getting right at the point that gave us a lot of concern in social security and gave the committees a lot of concern.

That is the possibility that we had interns and residents being paid out of part A on a salary basis and then the possibility of a duplication if you paid a fee to teaching physicians in part B.

So, the attempt to decide when there is an identifiable service by the teaching physician over and beyond the interns and residents is the crux of our problem here.

It would seem to the IOM panel that those criteria that I read which are the criteria in 227—that if those things are met, that then you have a teaching physician who is the personal physician of this patient who is doing things for him that are well over and beyond what an intern or resident may do for him.

Mr. COTTER. But that is the problem, to identify it properly.

Mr. YARMOLINSKY. If I may add, it is worth pointing out that the report also recommended hospitals may elect—and if they choose to go on the fee basis they cannot collect under part A for the general supervisory services of physicians so that is one way we thought we would get away from some of this possibility of confusion and duplication.

Mr. COTTER. I could see where an institution, yes, would make a great deal of money on part B and here you have part B, which is partly paid for by the medicare recipient.

Mr. DERZON. I would like to respond because I end up negotiating with physicians on a lot of issues.

I think you will find they are most effective in making sure institutions don't capitalize on their services considering it both uneconomic and they call it "unethical", which it is.

Mr. COTTER. I come back you know to reimbursements for service of anesthesiologists where they are on salary but the hospital makes enormous profit on some of these services.

I think the same is true of radiology. I can see where the same thing could develop in a situation like this.

Mr. DERZON. First of all, in the hospitals that were studies, the 15,000 teaching physicians in a sample, about one-half of them were totally independent. They had no relationships whatever in terms of their own income.

Another large share had no relationship with the hospital. They may have had it with the department or medical school or something way outside of the hospital so the ability of the hospital to control most of the doctors' income in most of the hospitals looked at in the sample is minimal.

In the case of the hospital based specialties, the ones you just mentioned, radiology and so forth, that is sort of a separate issue and the teaching hospitals are not that much different than most hospitals in the United States on that issue.

In our particular hospital there is a professional fee and a technical fee and the technical fee covers the hospital costs and the professional fee goes to the faculty and they divide it up according to what professors of radiology get, assistant professors, and so forth.

I don't see that that type of arrangement, which is quite commonplace, allows extensive profiteering by the institution on the physician.

I think that it is certainly the case in most places in California and I would say in most other places in the United States that is a common arrangement so the problems of teaching hospitals with respect to the way professional fee money flows is not that much different than in the nonteaching section.

The problems of monitoring as to whether physician's services were rendered at all on a public program are really not that much different.

In fact, I think there was evidence in the study that the teaching hospitals because of problems they had in Chicago and other places have been much more tightly scrutinized than the nonteaching hospitals where physicians are also billing for services.

Mr. Rostenkowski. Mr. Derzon, let me try to understand this.

Commissioner, you were reading from the regulations, were you not?

Mr. Ball. I was reading from the regulations proposed to implement section 227 and in our report we adopted those with one exception.

Mr. Rostenkowski. That is what I want to get to, the exception.

As I understand it under the regulations if the physician filled out all of the charts and conformed to all of the regulations that are written, he would then be, if elected, be paid directly; is that correct?

Mr. Ball. Yes.

Mr. Rostenkowski. All right.

Where you have a charity load is it not common that the hospital is paid and then the physician is paid by the hospital? Is that pretty much the way it works, the way the regulations were written. Your exception is that if he does all of these things then he can deal directly for payment; is that right?

Mr. Yarmolinsky. Not a hospital electing to go on the cost method.

Mr. Rostenkowski. Well, if electing that method, then they cannot be directly paid.

Mr. Yarmolinsky. That is right, no fees at all.

Mr. Rostenkowski. Is there an option? Let's suppose the hospital does not elect to go on a cost basis, then there is duplicate payment, payment to the hospital and physician?

Mr. YARMOLINSKY. No; because the hospital cannot collect for its patients on the cost basis and the hospital has to phase out in 2 years these payments out of part A for general and supervisory services of physicians.

Mrs. HANFT. I think the distinction is there are hospital costs separated from the professional service. It is entirely possible and this is the way it works now, that you pay for the hospital's services separately from the professional's services.

Some of the major county and municipal hospitals have voluntarily elected to have their professional services where they have salaried professionals paid on a cost-basis method, based on the salaries, for instance, and certain overhead.

It is taking place right now and as of January there were 27 such hospitals in the country now being paid for all services, both the inpatient hospital services and physician services on a cost basis.

There are hospitals where physicians are on salary but generate fees because they are providing personal identifiable services.

There are hospitals with no physician on salary and they bill independently. What you really have is a range of arrangements that is very, very varied and one of the reasons we concluded no one method of payment was appropriate for the entire teaching hospital universe was that these institutions are so varied and their arrangements with the physicians are very widely varied.

Mr. BALL. Mr. Chairman, could I back up and make a point that everybody I am sure is aware of—but perhaps it is a good reminder—so that when we take off on the teaching hospitals we realize how physicians in nonteaching hospitals are paid.

We have been focusing so directly on the teaching hospital that maybe the overall setting has been lost. The usual procedure under medicare is that nontechnical hospitals are paid costs under part A, but the physician bills for a fee, and there is no question about his entitlement to a fee.

No question is raised. That is the way part B operates, on a fee basis. The only problem, not the only problem but the main problem that develops, is when a physician is in a teaching hospital and some of the service may be rendered by an intern or resident and the question is: Does this teaching physician also render a service that makes his relationship to that patient the same as if he were in a nonteaching hospital?

Is he a personal physician to that individual? The 277 regulation said, yes, if he meets all of these things that I read, plus they had one other.

The 227 regulations proposed also that in order to pay the physician on a fee basis—just as if it were not in a teaching hospital—there had to be a prior relationship with that patient before he entered the hospital. It did not seem to us that this ought to be an absolute requirement. We thought it would be better to use the prior relationship as a screening test—that is if he did have a prior relationship entitlement to a fee would be automatic if he performed specific services.

There are cases where, even though there had not been a prior relationship, once the patient is admitted, then the teaching physician in the hospital picks up and establishes a personal physician relationship. It is exactly the same then as someone who had a prior relationship and we didn't think it should be treated differently. That is the one point where our recommendation differs from the proposed regulations on 227 as far as this test of personal identifiable service is concerned.

It is not as if we are saying the best thing in the world is to pay physicians on a fee basis. What we are saying is this: Medicare is set up so that in a nonteaching hospital there is a fee arrangement. Now, what do you do differently in teaching hospitals because of this special problem? We say under certain circumstances a fee arrangement is proper there.

That is what is going on today. Teaching physicians are being paid under certain circumstances on a ,fee arrangement.

I wish that we had been able to develop an absolutely 100-percent fool-proof answer to the complications in teaching hospitals, but there are some problems that don't have a complete solution.

What we are really saying is this: We can cut out some of the duplication that exists through dropping supervision costs when a hospital is on a fee basis. We can also establish much more careful criteria along the lines of 227 than existed in the past. We can make it clear if you don't meet such criteria then the only other way you can get paid is for the entire hospital to go on a cost basis and that is at your option.

I think that is a significant improvement.

Mr. Rostenkowski. If the entire hospital elects to go on a cost basis, there is less paperwork?

Mr. Ball. Yes.

Mr. Rostenkowski. I think my colleagues will agree that we have been sitting in this room listening to testimony relating to reimbursing hospitals and physician where the Government redtape and paperwork is absolutely—well, you know, absolutely driving people almost insane.

The end result is they don't want to really participate. They cannot afford not to participate but they don't like it.

What we are concerned with, genuinely, is to minimize the paperwork as much as possible.

Mr. Duncan.

Mr. Duncan. Let's get to the bottom line.

How much money will we save with the new program you are talking about?

Do you have any idea of the cost? I have never seen a change yet where we have saved money; I was really being facetious.

Mr. Ball. I would like to be sure my colleagues agree with what I am about to say, but my opinion is that from our study, and our examination of all alternatives, that we do not have any basis for arguing for one or the other, primarily on the basis of cost.

One of the problems if you go to the cost method is defining what you mean by "cost" but following the definition in our analysis, then as Mrs. Hanft indicated, some of the hospitals shifting from fee to cost, would result in a slight increase in cost to the Government there. I would not, however, want to rest on that very heavily.

Mr. DUNCAN. Maybe a major increase, sliding increase.

Mr. BALL. No, I think not. It is a fairly neutral situation. Whether you go on fee for service and elective cost as we propose—that is not go on the fee for service, but retain fee for service—or whether everyone is required to be on cost or everyone is required to be on fee for service. There is little basis for thinking the cost to the Government would be significantly decreased or increased either way.

Mr. DUNCAN. What reaction do you have to this from organized medical groups, if any?

Mrs. HANFT. We have not had a formal response from any of the organized medical groups.

We have some rumors that some people are unhappy with our recommendations on the specialty commission. We do not know in detail since we have not received a letter from them, the AAMC's position and I believe they will testify this morning.

Mr. DUNCAN. Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. I want to thank the panel very much for submission of this material and work you have done. We are very grateful to you for it. Thank you very much.

[The following was subsequently submitted for the record.]

SUPPLEMENTARY STATEMENT BY DAVID HAMBURG, PRESIDENT, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES

The following comments on certain points in the testimony presented by Mr. Thomas M. Tierney for the Social Security Administration and by Drs. David D. Thompson and J. Robert Buchanan for the Association of American Medical Colleges are hereby submitted for the information of the Committee.

On pages 5 and 6 of the prepared testimony, Thomas M. Tierney, Director, Bureau of Health Insurance, Social Security Administration made four statements about the Institute of Medicine report that require comment and correction. In the following commentary, the SSA assessment is quoted and then followed by our statement.

1. "First, it is important to note that we have serious concerns regarding the adequacy of the data on which the report was based. One result of the lack of data is that the Institute's findings cannot be generalized to all teaching hospitals. For example, in order to properly address the Congress' charge in section 15(c)(1), P.L. 93-233, it would be necessary to have comprehensive financial data on the complex fiscal operations of teaching hospitals generally. Data on fee collections, however, were apparently available from only 10 out of 81 hospitals, and in the case of six of these hospitals, information about the percentage of fees paid by Medicare and Medicaid was either unavailable or described as a "low estimate." Without such data as well as further documentation of sampling of the sampling process and information on the size and variance of each stratum, the validity of the findings cannot be assessed."

First, the data situation is not as reported in the SSA testimony, complete data were available (and presented on pages 128–131 of Part II of the report) for 10 of the 17 *schools* studied, thus representing data from 30 of 81 non-federal sample *hospitals*. "Low estimate" was used to describe data (from a new billing system) for one school in its relation to one, not six, hospitals. On pages 209–211 data are presented for professional service income in 21 hospitals and used to estimate the effect of changes in payment methods.

The sampling process is described in Parts II and III of the report and a description of it was furnished SSA in November, 1974 when the sample was selected.

A major finding of our report was the wide variability in organizational and financial arrangements that link teaching hospitals, medical schools, and teaching physicians. Another major finding was the wide variation in the depth and reliability of financial information among teaching hospitals and medical schools. From the standpoint of this study, the principal gap in the data is the amount of payment received by teaching physicians for patient care services in the aggregate and from Medicare and Medicaid. These findings were reported throughout Part I, Chapter 1, and Part II, Chapters 1–6, which deal with teaching hospitals.

This problem was recognized early in the study and the study group concluded that it would be impossible to get complete data on professional service payments unless the following conditions could be met: (1) complete reconstruction of institutional financial reports using standardized accounting definitions and decisions; and (2) access to Internal Revenue Service records for each teaching physician; and (3) access to each teaching physician's or physician groups' records in order to separate the charges made for services in teaching hospitals from those made for services rendered in private offices and non-teaching hospitals. The study group did not believe that Congress intended it to have the legal authority (subpoena power) or to take the length of time that would be required in order to satisfy those conditions.

Since the study came about as a result of legislation (Section 227, P.L. 92–603), which attempted to accommodate different kinds of teaching hospitals and their financial relationships with teaching physicians, it seemed important to describe the diversity of the institutions, at least on a representative basis. The policy development process must be based on adequately representative data, even though it may be incomplete, which can be used to support the process.

Recognizing the importance of securing representative data, the IOM sought the services of a recognized expert in sample design. Mr. Nathaniel Pigmann, the mathematical statistician for the Social Security Administration. In consultation with IOM staff, Mr. Pigmann designed the sampling process which was used by staff to select the institutional complexes included in the study.

The absence of data for certain institutions is representative of the availability of data in a carefully chosen sample, and is more representative of reality than would be complete data from a poorly selected sample of institutions.

2. "The Institute of Medicine Steering Committee has made eight recommendations in response to the Congressional charge which we are discussing here today. Of these, the first four contain six recommended payment methods five of which are fee-based. In citing the lack of data as the major reason for an inadequate evaluation of these alternative methods, the Institute concluded that the revenue differences among the five charge-based methods could not be done accurately and was therefore not pursued. The additional recommendations relate to peripheral issues and not specifically to payment methods."

The study recommends three payment methods not six; and two, rather than five of these methods, are fee-based. Of the eight recommendations made in the study, only three contain *recommended* payment methods: (1) cost reimbursement as currently allowed under Section 15, P.L. 93–233; (2) a "unified" method of fee-for-service payment which recognizes current practices in a handful of hospitals, but suggests certain modifications; (3) a fee-for-service payment method similar to the suspended Section 227 but excluding the Part A payment for teaching and supervisory services and the presumptive patient liability test. The fourth recommendation suggested three payment methods *for experiment or demonstration.* No estimates of comparative program costs could be made for these payment methods since they are either not in use or the amount to be paid would be determined through negotiation of coverage, patient numbers, and payment levels. The four remaining recommendations suggest legislative or administrative changes.

Differences in reimbursements under the two fee payment methods cannot be reliably estimated because no institutions now use the unified method in the form as recommended, and thus, no data are available anywhere. Estimated differences in program cost for the fee and cost payment recommendations are presented on pages 209–211 of the report. Of necessity, the estimates are based on assumptions regarding a definition of costs and the variations in usual and customary charge levels across the county.

3. "We have reservations about the Institute's conclusion that the most appropriate methods of payment for physicians' services in teaching hospitals is the 'fee-for-service' approach and we believe that inadequate attention seems to have been paid to alternative cost reimbursement arrangements."

The Steering Committee did not conclude that fee-for-service is the most appropriate method of payment for physicians' services in teaching hospitals. The report states (on page 5) that "The analysis indicated that no one payment method would constitute appropriate and equitable compensation in all teaching hospital circumstances, or could be applied universally without adverse effects on graduate medical education in the United States." This point is addressed in more detail on page 39 of the report.

It is important to repeat that if the study recommendations were implemented, fee-for-service payment would be appropriate *only* if the criteria for personal and identifiable service were met for individual patients and physicians. If the criteria were not met, *no* payment would be made unless all the physicians in the hospital had elected to be paid on a cost basis. Where the physicians in an institution elected to be paid on a cost basis, no fee payments would be made (except for special community-service units, such as burn and renal dialysis centers).

4. "Also, the Institute's report does not explore other sources of financing teaching hospitals or paying for physicians' services provided to Medicare and Medicaid beneficiaries. This is, we think, unfortunate considering that for many years concern has been expressed regarding the appropriateness of the use of third party funds, including Medicare funds, in subsidizing the training of physicians as part of patient care services."

The reason the report does not "explore other sources of financing teaching hospitals or paying for physicians' services provided to Medicare and Medicaid beneficiaries" is that (as noted on page iv of the report) they did not seem to be encompassed in the specifics of the five congressional charges as understood by the IOM Steering Committee. The Steering Committee understood that it was to address the question of appropriate and equitable reimbursement for services of teaching physicians to Medicare and Medicaid patients. Under current policy and law this issue must be studied in the context of all payors as the study group has done. In that context, if one or two major payors for patient care unilaterally change their policies, the burden would fall on the other payors for patient care rather than on some as yet unidentified sponsor of graduate medical education.

The Steering Committee points out, however, that, if there were a major change in the mechanisms for paying for patient care. such as national health insurance, then another long-range solution might be appropriate. The details of such a solution would depend, to a large degree, on the specifics of any national health insurance program that might be passed by the Congress.

The testimony of the Association of American Medical Colleges (AAMC) comprehensively addresses the entire report. The IOM Steering Committee looks forward to the opportunity to testify on the manpower issues addressed in the study but feels that it should respond to the AAMC testimony so that the record of his hearing will be complete.

With respect to the reimbursement of teaching physicians:

1. The AAMC suggests that the study should have developed a "management control procedure" that would differentiate between "educational supervision" provided jointly with patient care and that provided separately from patient care. This is an important institutional management problem but it is not a problem that the Institute was asked to address. The activity analysis instruments employed in collecting data for the study could be used for this purpose, however.

2. The AAMC testimony states that the IOM report is ambiguous with respect to the definition of cost to be employed in the recommended cost payment method. The report states specifically (page 40, Part I) that "[cost] payment for physician services should reflect as closely as possible the full costs of providing the services." "Full cost" is discussed further on pages 209–211 and is defined to include not only physician salaries but such costs as billing and collection, office space for practice, insurance, support staff, supplies, and equipment.

With respect to specialty and geographic distribution of physician manpower:

The AAMC has interpreted the IOM recommendation for a quasi-public independent physician manpower commission as giving the proposed commission mandatory control over the number of training positions by specialty. The recommendation; as it appears on pages 64 and 66 of the report, specifically states that control of the number of training positions would be voluntary *unless* after three years' experience, "the Secretary of HEW finds that the commission's determinations have not been implemented." In that event, legislation would be requested "to reconstitute the commission as a federal advisory committee to himself and to permit the withholding of Medicare and Medicaid funds from residency programs in specialties considered in excess supply by the commission."

The AAMC also finds unacceptable the proposed role of the Liaison Committee on Graduate Medical Education (LCGME) as the body to decide where training positions should be reduced in specialties found in excess supply. The LCGME is the accrediting body for allopathic graduate medical education programs. It is a component of the Coordinating Council for Medical Education (CCME) which is composed of the American Medical Association, the American Hospital Association, the Association of American Medical Colleges, the Council of Medical Specialty Societies, and the American Board of Medical Specialties. The IOM Steering Committee made its recommendations based, in part, on discussions with Dr. William Holden, an ex-officio member of the CCME and Chairman of its Committee on Physician Distribution.

In those discussions, Dr. Holden advised the Steering Committee that for its recommendations for *voluntary* control of the number of specialty training programs and positions to have an effect, the responsibilities of the LCGME with the concurrence of the CCME could be expanded to this extent. In its rejection of this expanded role for the LCGME AAMC argues that: (1) it is an inappropriate role for an accrediting body and (2) socially desirable goals in physician distribution are already being met. Yet, the argument is presented simultaneously that the CCME should take on the functions the IOM Steering Committee prescribed for the commission, without specifying a mechanism for implementing any recommendations it might make. The AAMC represents in its testimony that within this context "the need for input from individuals outside the professional groups directly involved in graduate medical education is definitely acknowledged; however, majority representation from these 'other sectors' is questioned," thus abandoning its own previous position, *sub silentio.*

The AAMC also makes much of newly-analyzed data that purport to show that the distribution of training positions and trainees is shifting toward the "contact" specialties (family practice, general practice, general internal medicine, and general pediatrics). This claim is based on an analysis of first-year training positions for internal medicine and pediatrics, *in total,* thus by definition, including those which lead to subspecialty training in the fourth or later years. Although we would agree that our recommendations "must be examined from the perspective of dynamic changes in graduate medical education," we do not believe this evidence is sufficient for us to alter the recommendation. That is why we recommended a permanent quasi-public commission to conduct studies and set policy based on its findings.

Mr. Rostenkowski. Mr. Tierney?

STATEMENT OF THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY AL DIAMOND, DEPUTY DIRECTOR, AND CLIFTON GAUS, OFFICE OF RESEARCH AND STATISTICS

Mr. Tierney. First of all, Mr. Chairman, our apologies for the late appearance. We set out from Baltimore at 10 to 7 with every expectation to be here, but you have awful messy weather. I would like to introduce our Assistant Deputy Director, Office of Program Policy in the Bureau of Health Insurance, Alvin Diamond, and Clifton Gaus with the SSA Office of Research and Statistics.

I have a statement, Mr. Chairman, which largely sets forth the chronology of problems of reimbursing teaching physicians and the joint efforts of Congress and of the administration to try to answer them, but I assume, and I did not get to hear all of what Mr. Ball said, but I know him well enough to assume he probably laid it out for you clearly already.

So with your permission I would just like to file my prepared statement for the record and answer whatever questions we can for you, sir.

Mr. Rostenkowski. You are filing your formal statement, Mr. Tierney, is that it?

Mr. TIERNEY. Yes.

[The prepared statement follows:]

STATEMENT OF THOMAS M. TIERNEY, DIRECTOR OF THE BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION, HEW

Mr. Chairman and Members of the Subcommittee, I am pleased to be with you today to discuss Medicare reimbursement for services of physicians in teaching hospitals and the Institute of Medicine's report on this subject.

As you are aware, the Social Security Administration, at the direction of the Congress and as set forth in section 15(c) of P.L. 93–233, entered into a contract with the Institute of Medicine (IOM) to conduct studies concerning Medicare-Medicaid reimbursement policies and various medical manpower issues. My remarks today will be confined to issues surrounding the first part of that study, that is, appropriate and equitable methods of reimbursement for physicians' services in hospitals which have a teaching program approved as specified in section 1861(b)(6) of the Social Security Act. I believe it would be helpful first of all to review the background of this complex issue.

The original Medicare law was silent about the precise methods for paying for the services of supervisory and teaching physicians who work in the hospital setting. Late in 1968, the practices that would ultimately lead to the study we are discussing today came to the attention of the Administration and the Congress. The issue was highlighted by an investigation and report undertaken by GAO for the Senate Finance Committee concerning Medicare payments for supervisory and teaching physicians services. The search for a resolution of the problems resulted in section 227 of P.L. 92–603, the Social Security Amendments of 1972. However, implementing this provision, in turn, raised additional issues and late in 1973, Congress in P.L. 93–233 authorized the study by the Institute of Medicine of the National Academy of Sciences.

Now just what is this problem that has caused so much difficulty for a number of years? The basic question is this—what is the appropriate and equitable method (or methods) for Medicare to pay physicians where they use the services of interns and residents in providing care to their patients?

We first have to begin with the history and structure of Medicare. As you know, Medicare has two parts, the hospital insurance program, part A, and the supplementary medical insurance program, part B. Basically, part A pays hospital costs, which include a portion of the salaries of interns and residents and supervising physicians participating in education programs in a hospital. Part B pays for the personal services of the physician to a particular patient. However, in many teaching hospitals personal physician services for individual patient care are not easily identifiable.

There is no question about the appropriateness of payment under part B for physicians' services to private patients in the typical community hospital and other teaching settings where patients are expected to pay fees for these services. On the other hand, in the program's early years, charges were billed and paid under part B for physician services provided in teaching hospitals where the teaching physician was not personally participating in the care of the patient. Although the teaching physicians took legal responsibility, care actually was provided by interns and residents.

To deal specifically with this problem, the Bureau of Health Insurance issued several sets of instructions between 1967 and 1972 which attempted to clarify the conditions under which a billing could be considered and the way in which bills for teaching physician services should be treated.

In August 1967, regulations were issued specifying the conditions under which payment could be made under part B for the services of supervisory and teaching physicians. The regulations indicated that the billing physician must either render patient services personally or be the Medicare patient's attending physician, that is, provide personal and identifiable direction to residents and interns assisting in the care of his patient. In addition, the character of the services was required to be the same as the physician provided his other paying patients.

Intermediary Letter No. 372, issued in April 1969, spelled out in some detail those factors necessary to establish that an attending physician relationship existed between a physician and his patient. Services other than direct patient care, e.g., teaching, research, administration, etc., were again emphasized as only reimbursable as hospital costs, generally under part A.

Despite these efforts, the problem persisted and attracted a great deal of attention. In November 1971, the General Accounting Office released a summary report, "Problems in Paying for Services of Supervisory and Teaching Physicians in Hospitals under Medicare," which raised questions about possible abuses at six hospitals. The congressional awareness generated by this and the earlier GAO reports led to a legislative proposal by the Congress intended to correct the abuses in connection with reimbursement of teaching physicians. This proposal was enacted into law as section 227 of the Social Security Amendments of 1972 (P.L. 92–603).

Section 227 stipulates that services of teaching physicians are to be reimbursed on a cost-related basis unless: (1) the hospital traditionally charged all patients and collected from a majority on a fee-for-service basis, or (2) the patient for whose treatment a fee-for-service billing was submitted was in fact a bona fide private patient. Further, for services provided by volunteer physicians, the amendment specified that a salary cost would be imputed, equal to the porated costs of full-time salaried physicians. These amendments were to be effective for accounting periods beginning on or after July 1, 1973.

Proposed regulations implementing section 227 were published in the July 19, 1973, *Federal Register* and a volume of comments was received. In its comments, the Association of American Medical Colleges included a report to the Secretary that, among other things, assessed the adverse financial and program impact of the proposed regulations on five member hospitals. While the data presented in the study were too limited to serve as a basis for drawing conclusions about the appropriateness of the regulations, they did raise questions about the impact of such regulations and the advisability of implementing them without further study.

Many others who commented on the regulations brought their views to the Congress. Subsequently, Congress enacted P.L. 93–233 which deferred the effective date of section 227 to allow the National Academy of Sciences, Institute of Medicine to conduct a study of teaching physician payment and related issues. In addition, P.L. 93–233 also included an interim provision under which the services of a teaching physician would be reimbursed on a reasonable cost basis if the hospital elected to receive any payment due under title XVIII for the reasonable costs of such services and if all physicians in the teaching hospital agreed not to bill the program for services rendered Medicare patients. As you are aware, we are now operating under this provision of P.L. 93–233. which was extended by P.L. 94–368, while the Administration and the Congress study the recommendations of the Institute of Medicine.

A detailed analysis by the Social Security Administration on the portion of the study which we are discussing today will be formally transmitted shortly to the Chairman, House Committee on Ways and Means and the Chairman, Senate Committee on Finance. I will just make a few general comments regarding our assessment of the IOM report and then I will be pleased to respond to any questions you might have.

First, it is important to note that we have serious concerns regarding the adequacy of the data on which the report was based. One result of the lack of data is that the Institute's findings cannot be generalized to all teaching hospitals. For example, in order to properly address the Congress' charge in section 15(c)(1), P.L. 93–233, it would be necessary to have comprehensive financial data on the complex fiscal operations of teaching hospital generally. Data on fee collections, however, were apparently available from only 10 out of 81 hospitals, and in the case of six of these hospitals, information about the percentage of fees paid by Medicare and Medicaid was either unavailable or described as a "low estimate." Without such data as well as further documentation of the sampling process and information on the size and variance of each stratum, the validity of the findings cannot be assessed.

The Institute of Medicine Steering Committee has made eight recommendations in response to the Congressional charge which we are discussing here today. Of these, the first four contain six recommended payment methods, five of which are fee-based. In citing the lack of data as the major reason for an inadequate evaluation of these alternative methods, the Institute concluded that the revenue differences among the five charge-based methods could not be done accurately and was therefore not pursued. The additional recommendations relate to peripheral issues and not specifically to payment methods.

We have reservations about the Institute's conclusion that the most appropriate methods of payment for physicians' services in teaching hospitals is the "fee-for-service" approach and we believe that inadequate attention seems to have been paid to alternative cost reimbursement arrangements. Also, the Institute's report does not explore other sources of financing teaching hospitals or paying for physicians' services provided to Medicare and Medicaid beneficiaries. This is, we think, unfortunate considering that for many years concern has been expressed regarding the appropriateness of the use of third party funds, including Medicare funds, in subsidizing the training of physicians as part of patient care services.

Notwithstanding our concerns about some of the report findings and recommendations, we believe the report will prove useful as a basis for developing further legislative proposals as well as for improving the administration of the Medicare program.

The Department is not at this time prepared to offer specific legislative recommendations to Congress on the basis of the IOM study. We will be studying the raw data collected by the IOM and attempting to develop alternative sources of data on teaching physician reimbursement. The Administration plans to present legislative recommendations early in the next session of Congress.

Mr. Rostenkowski. The 1972 legislation sought to encourage teaching hospitals to elect cost reimbursement for physicians' services by exempting these payments from the usual part B requirements.

Also, payment can be made on a salary equivalent basis for the voluntary physicians donating their services to a teaching program. What has been the reaction of teaching institutions to this reimbursement otpion?

Mr. Tierney. From our point of view, it has been largely negative, Mr. Chairman. I think the hospitals have felt that even though this would appear to be a sound approach to the problem, it nevertheless is going to ultimately result in lower reimbursement to the institutions and a lesser contribution toward medical education and it is understandable they therefore find this unsatisfactory.

Mr. Rostenkowski. Under your present policy, teaching physicians who spend the majority of their time teaching and in caring for nonprivate patients, can qualify for fee reimbursement but the medicare allowable fee is supposed to be related to physicians' salaries rather than to the fee levels of the privately practicing physician. Are you as a practical matter getting the kind of information needed to apply this requirement?

Mr. Tierney. No, sir, I do not think we are. I am sure it has already been pointed out to you, and I am sure you knew beforehand, this is an extremely intricate area and it is easy to philosophize about different approaches but it is extremely difficult to administer some of those approaches. When you talk about the relation of fees to the physician compensation, we get a lot of data and the carriers try their very best to establish acceptable levels.

But in answer to your question, I would have to say I do not think we really can conscientiously say that that system works. For example, a doctor gets $25,000 a year so we ought to relate his fees to this amount. We estimate that he sees so many patients to work up a charge from that cost base. Well, that is fine if all of the estimates are right. If, however, the doctor sees twice as many patients obviously the estimates and the resulting payments are very wrong. And you never know at any point in time whether he is going to provide more services or not. Along in July you may see that he is running ahead of what was estimated but maybe the number of services will slack off or maybe they will increase. All I say, Mr. Chairman, is that the purely administrative task of trying to keep track of how much should be expended for these services is very difficult.

Mr. ROSTENKOWSKI. The Institute of Medicine believes that a fee-base method of payment is appropriate when a teaching physician provides personal and identifiable services to program beneficiaries or directly supervises the house officers. This is essentially the test that caused all of the misunderstanding and noncompliance that gave rise to the 1972 legislation which was intended to simplify administration by establishing presumptive tests.

Do you believe you are now able to apply the kind of personal identifiable service requirements that IOM proposes or do you believe there is still need for kinds of administrative presumptions that were enacted in 1972?

Mr. TIERNEY. Again, from an administrative point of view and from my point of view, if you will, Mr. Chairman, I think you have to establish some presumptions. These other things make very sound sense. But we do get back into the position we were in prior to 1972 and back in the days of the well-known Cook County situation.

This is in keeping with the statement you made a while ago about recordkeeping and bookkeeping—well, this becomes a massive data evaluation program in order to establish whether the doctor really provided the service, was actually present or treated the medicare patient as he does his other patients. That leads into medical records. If the medical records do not indicate precisely the nature and extent of the services well, then you should not be paying for it.

But a doctor might well have done the job and have done it quite acceptably and should, therefore, be reimbursed, but did not do a good job of making notes in the medical records. So it leads to interminable arguments I am sure also to some inequities.

On the other side of the fence, apart from his not getting reimbursed, because the records are not good, another physician may write good records and really not do much other than that. I think ultimately we have to have some kind of broad classification and assumptions, Mr. Chairman. There will always be situations in which there is an obviously close personal relationship, no question but it is a personal physician and no question but what he rendered the services, but you have to be able to determine that in some way other than checking through massive files of papers.

Mr. ROSTENKOWSKI. Mr. Duncan?

Mr. DUNCAN. Mr. Tierney, this is a related item but I have been quite concerned about the study that was authorized in 1972 of reimbursement of physician extenders. In fact, I have some questions that I outlined in the Congressional Record yesterday to be delivered this morning. It is on page 10152. It appears to me that there has been an unnecessary and undue delay in filing that report and people cannot get answers to questions that they send to your Department. If you would read those questions and make some effort to answer them, I would hope you will, I would appreciate it. In fact, this part of the record of these hearings.

Mr. TIERNEY. I will be glad to, Mr. Duncan.

Mr. DUNCAN. I understand now we cannot get any basic information as to what happened in the study and it is 4 years.

Mr. Tierney. That may be an overstatement, I do not know, but let me say, if I may, Mr. Duncan, that when we find it very difficult to arrive at an answer to something, or when congressional committees say, "We listened to all of the testimony and all of the experts but we are not sure how to evaluate what they talked about," or "Why we do not have experiments?", or "Why we do not have studies?" Usually there is really not much of an answer. I do not mean to say that this is a "copout" because we all do it.

I think this problem extends into the area of physician extenders, a study that rather clearly sounds like a great idea. There are a myriad of reasons for delay, but I tell you that it is not because we are deliberately—that we do not want to move ahead in the area of physician extenders. One thing that it is important to remember is that these people are not generally licensed. They are fine people, no question about it. However, there are neither national licensure requirements nor national standards. They happen to be usually people who, for one reason or another, have a kind of medically related background and education. When you start injecting them into a Federal health program, some kind of compensation for that class of people has to be considered. In that regard, you should remember we do not pay fees to registered nurses, who are licensed graduates. There is a lot of difficulty. I would only like you to understand it is not a case of our just sitting around and doing nothing. I assure you it is a hard problem. The head of our Office of Research and Statistics has some definite ideas.

Mr. Duncan. Even that would help if we can get that much of a report but we do not seem to get anything. I think anyone would agree that in 4 years, something that should take 6 months, which you have taken 4 years on, and now I understand you are getting ready to spend a great deal more money to hire some professional consultants to look further into it. We do not have a scrap of paper or report of any kind in 4 years and I think it is ridiculous.

Mr. Cotter. Will you yield?

Mr. Duncan. Yes.

Mr. Cotter. Beyond that, the law specifically required them to report by June 1, 1976.

Mr. Duncan. Yes. And the GAO in their report, absolutely requested it be expedited. Someone is sitting around. I do not know who it is and with all due respect to you who I have great regard for but some authority should respond and I am expecting some kind of answer to questions I had on the special order of the House yesterday.

Mr. Tierney. It will certainly be answered.

Mr. Duncan. Thank you.

Mr. Cotter. Thank you very much. You are required to make a study of this and you were supposed to report to us by the first of June, is that correct?

Mr. Tierney. That is correct.

Mr. Cotter. Can you explain to us why this was not made available to Ways and Means?

Mr. Tierney. You are speaking now about the teaching physician study?

Mr. Cotter. Right.

Mr. Tierney. Yes. I can tell you the chronology although I do not know you would regard it as a full explanation. That study was completed and turned over to us, when I think it was scheduled to be, around March 1. It is a massive study involving a massive accumulation of data, although somewhat inconclusive. I think even the Institute would agree. The question addressed to it was a tough one to come with with black and white answers to. But, also, the Congress, quite appropriately, saw fit to add a couple more facets to the study.

One was utilization of health manpower, in other words, the attempt to try to find some answer to geographical abnormalities in number of physicians and health care and what not. Also, added on was a study and a recommendation about foreign medical graduates.

We got the study. We reacted to the monetary side of the thing. We completed our evaluation of the report. Since we are not in the business of foreign medical graduates or distribution of doctors, those items went to the Public Health Service and to the Assistant Secretary for Planning and Education in HEW for their evaluation. The evaluations were divergent, Mr. Cotter. Some people felt very strongly one way and some people felt another. The time which has intervened has been spent in trying to reach a position that the Department could recommend to the Congress as a future approach to some action.

It is my understanding that within the next few days the Department will make the report available to the Congress on all three aspects, not just the teaching physicians.

Mr. Cotter. When will it be available to us?

Mr. Tierney. I am told "within a few days," Mr. Cotter.

Mr. Cotter. You know, the Institute of Medicine is on a tight timetable, too, but they have been able to complete their work. We are in a tough position here. This is a real can of worms. Here we are "neophytes" and we are looking to you for guidance and we do not even know whether the program is enforceable or not.

Mr. Tierney. I agree with you, Mr. Cotter. We should have had that report here to you sooner. Again, I would say, as I said to Mr. Duncan, it was not because it was lost on somebody's desk but it was because it was under serious debate by serious people as to what recommendations should be made.

Mr. Cotter. Do you have any thoughts now, Mr. Tierney, on whether it should be adopted or not?

Mr. Tierney. The Institute's report?

Mr. Cotter. Yes.

Mr. Tierney. Well, we have this situation.

Mr. Cotter. You must have some advance notice as to whether you like it or do not.

Mr. Tierney. If I may, can I give you the Social Security Administration's position and some thoughts of my own. This is not said in any way critical of the Institute, because I think they did a good job of addressing and defining the problem, accumulating data and pointing out various ways to approach the problem. That is about all they could do. Sometimes there is an assumption that conducting a study or demonstration will of itself provide new and better solutions to some of these difficult problems. We know that is not necessarily the case. Often the choices are limited, and a study can produce nothing new. I think that is the case with teaching physician reimbursement.

There are only four or five ways, and when you have gone through those, that is about the end of it.

I might say I think that is the conclusion that the Institute reached, that some teaching physician services ought to be paid on a cost basis and some teaching physicians ought to be allowed to make charges for actual personal services to medicare patients—if they make and collect those charges from other patients on the same basis and so forth.

I think the time will come when the real answer to this problem will be confronted and that is to remove such items as medical education, research, capital expansions, malpractice insurance costs, depreciation, interest, and maybe even administrative costs from everyday patient care costs. That is where they are loaded now. We pay for these items in per diems just as if they were part of direct health care costs for people. If this were done, I think we would find the actual costs of patient care would be quite reduced. However, as long as the only source of financing for all of these other things, both from the public and private sector, is in everyday reimbursement of average costs—two things happen. First, these cost elements are never identified very well and, second, you never really get much control over them. We have talked about planning for 25 years that I am aware of and I think we have a plan and everybody agrees but one of the problems is the planners make their plans and after they get through, no one pays too much attention to the plan because there is no way for the planners to enforce it.

If we ever get to the day when instead of paying every hospital in America a little for depreciation, capital indebtedness, interest, and that sort of thing in their patient costs and instead identify them, and set them aside and put them in the hands of the planners so they have clout, than maybe there will be planning that is financially effective. Responsibility for medical education costs should not be with the patient lying in the bed, but should be borne by the whole community.

However, the only place, at the moment, that the money can be gotten is out of the per diem cost and that leads, Mr. Cotter, to all of the problems we are talking about as to which is the nicest way to do it and which is the least complicated and the same time most responsible. I would say to you, there is never going to be a very good solution to that.

Mr. Cotter. The Department, I can conclude then, is neither for or against it?

Mr. Tierney. The latter part of this more eloquent statement I guess represented my views. I think the Department is for the report to the extent that the Institute's report really lays out an approach. I do not mean to say this in any derogatory sense, but I know, from reading it, the institute lays out eight different ideas. They show the pros and cons of each. So you cannot really be against the report.

Mr. Cotter. But you are not for it?

Mr. Tierney. I think this.

Mr. Cotter. I mean the limitations of it?

Mr. Tierney. I am not sure we are for it; that is, I am not sure it zeroes in on everything we want. I think the indication is that payment should be continued on a cost basis for medical education, such as the cost of interns, residents, physician teaching, supervision, and the rest. And in specific, identifiable situations when the physician is not teaching, not supervising but taking care of a patient in the hospital and rendering personal services, he ought to get a fee paid. If that is the one alternative that comes out of the Institute's report as being, from my point of view, the most easily administrable, efficient and equitable, we are in full agreement with it, but I do not think they full zeroed in on saying "This is the way to do it."

Mr. Cotter. Do you think such a program could be administered equitably and fairly to everyone concerned?

Mr. Tierney. Yes; we have been doing it for 10 years.

Mr. Cotter. I mean a fee type.

Mr. Tierney. Everybody has certainly agreed that done correctly this is equitable and fair.

Mr. Cotter. No; I mean the proposal as to the Institute of Medicine, do you think it could be done fairly.

Mr. Tierney. It can be done, Mr. Cotter. It all depends on all of the things we have been talking about here. It involves a massive amount of recordkeeping, and it involves a lot of people going through the records and saying, "Well, this is good and this is not good," but you can do it; yes, sir.

Mr. Cotter. It can be done, then?

Mr. Tierney. It would be a wonderfully simple thing, if you could say to an institution "Here is the Federal share of what you need to run medical education in your institution. Do not give us all of these pieces of paper saying: 'Yes, I took this man's temperature' or 'I did not.'" Tell us instead, "This what we feel medical education needs and should receive." That is a simple way, but it can be done. Short of this, Mr. Cotter, I say to you that GAO or somebody else will always find that the rules have been violated to some extent.

Mr. Cotter. I suppose so. On page 6 of your statement, you mention, "Also, the Institute's report does not explore other sources of financing teaching hospitals or paying for physician's services."

Do you have a recommendation yourself?

Mr. Tierney. Well, I think that is what I was trying to say, Mr. Cotter, that like most of the analyses this report again zeroes in on "How do we get money out of the patient daily health care per diem costs or out of the third-party payers." What I am trying to say is that the Institute's report did not address this issue. I do not know that the Institute was charged to address it or the much bigger picture—"Is there a different way entirely? Can we divorce these expenses from patient care costs and address them simply, openly, honestly?" Then you would not have to go through any of this foolishness.

This is not criticism of the Institute but I think it is the kind of expanded approach that we are going to need in our thinking.

Mr. Cotter. I wish the Department could be more helpful to us. Frankly, I am disappointed. I have an open mind I know it is a can of worms and other members feel likewise, but it is something we have to address. We do not have the staff here or expertise to go into this. We have to look to people such as yourselves for guidance.

Mr. Tierney. Mr. Cotter, it is most challenging and complimentary that you think we can guide you. However, I think this is a situation in which we cannot guide you much. We are all in the same boat. We have fiddled around with the problem for 10 years and we have not found a solution. The Institute made a vast study and collected a lot of data but did not really settle on any precise way of going about it. But I understand your position entirely. Since we seem not to know what to do about this problem, why not get a study and go out and experiment. I think we are going to be further frustrated. For example, Mrs. Jones is lying in the hospital during her operation. If the intern or resident comes in and takes care of her, it is one thing. If the doctor comes in and does it himself, it is another so long as he makes a record of his own. These are entirely different ways of handling the same situation.

Mr. COTTER [presiding]. Thank you very kindly.

The next group is from the Association of Medical Colleges, Dr. David Thompson and Dr. Robert Buchanan.

First, I would like to make a statement that any of this morning's witnesses, if they would like to make supplementary statements for this record they will be admitted without objection.

Gentlemen, it is good to have you before the panel. You may proceed at your leisure.

STATEMENTS OF DAVID D. THOMPSON, M.D., CHAIRMAN-ELECT, COUNCIL OF TEACHING HOSPITALS AND J. ROBERT BUCHANAN, M.D., CHAIRMAN-ELECT, COUNCIL OF DEANS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY RICHARD M. KNAPP, DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS

Dr. THOMPSON. Thank you.

Mr. Chairman and members of the committee, I am David D. Thompson, M.D., chairman-elect of the council of teaching hospitals of the Association of American Medical Colleges (AAMC) and chief executive officer of the New York Hospital, the major teaching affiliate of Cornell University Medical College. I am accompanied by J. Robert Buchanan, M.D., chairman-elect of the AAMC council of deans, and dean of the Cornell University Medical Colleges, and also with me is Richard M. Knapp, director, Department of Teaching Hospitals, Association of American Medical Colleges.

I might say at this point, it is not simply a coincidence that I, as the chief executive officer of a teaching hospital and on my left, Dr. Buchanan, council of deans, are here together. Indeed it illustrates, as has been amply pointed out this morning, the intricacies and complexities of the problem of payments to teaching physicians.

It is not solely a teaching hospital problem nor a medical college problem for the very simple reason that the individuals we are talking about, the teaching physicians, are, on the one hand, the faculty of the medical college, and, on the other hand, the attending physicians on the staff of the teaching hospital. These are the same people. Clearly, the dean of the medical college and the director of the hospital have to meet and discuss the matters in relation to these positions jointly, not the least of which is how they are compensated. They are indeed providing very important services as faculty, in teaching of undergraduate medical students and graduate medical students, or, as we call them, "house officers," and they are, also, of course, responsible for the care of the patients in the hospital. In that setting, they are providing the services to patients as private physicians, as well as providing the supervision and the education for the interns and residents on the house staff.

The Association of American Medical Colleges represents all of the Nation's medical schools, 400 major teaching hospitals, and 60 academic societies. Thus, the recommendations of the Institute of Medicine study on payment for physicians in teaching hospitals, the specialty and geographic distribution of physicians, and foreign medical graduates are of direct and significant interest to the Association's members and have far-reaching implications for their programs.

The Association of American Medical Colleges has carefully studied the final report of the Institute of Medicine's "Medicare and Medicaid Reimbursement Study," published in March. It is our understanding that the hearing this morning is to be directed to the issues concerning payment of physicians in teaching hospitals under medicare. However, for your consideration, I would like to insert in the record a document approved by the AAMC executive council and attached to this testimony which is addressed to all issues in the final report.

Mr. Chairman, with your permission, I should now like to ask Dr. Buchanan to begin our testimony.

Mr. Cotter. Proceed.

Dr. Buchanan. Thank you, Mr. Chairman. My purpose is to emphasize some of the educational issues relevant to the institution's study recommendation.

GRADUATE MEDICAL EDUCATION AND THE TEACHING PHYSICIAN

Medical education in America has undergone a profound change during this century. In the early 1900's, students entered independent medical practice directly following graduation from medical school. By the 1930's, a single post-M.D. year of internship had become a general part of medical education to supplement and expand clinical training in the medical school. Following the Second World War, the accelerating pace of biomedical research resulted in spectacular advances in the prevention, diagnosis, and treatment of disease. The growing complexity of medicine brought about the need for extending the post-M.D. period for gaining additional knowledge and clinical skills and, as physician specialization increased, hospital-based residency programs became an integral part of medical education and training.

Today, contemporary medical education begins in the medical school and continues through residency training for all physicians in all specialties, including family practice, general internal medicine, and general pediatrics. During this educational process, the student of medicine advances from classroom lectures and laboratories in the medical school setting to supervised patient care activities in the teaching hospital. Naturally, as the physician in professional training acquires greater competence and more sophisticated clinical judgment, the faculty role changes from one of active didactic instruction to supervision and evaluation, and the house officer participates more actively in the care of the patient.

A teaching hospital has multiple objectives, one of which is to provide the environment and resources for educating future generations of physicians. To fulfill its educational responsibility, the teaching hospital must incur costs over and above those incurred by nonteaching hospitals. The teaching hospital incurs costs for housestaff stipends to support interns and residents who, while participating in patient care services in order to learn, are primarily in the hospital setting for their professional education. Second, the teaching hospital incurs compensation costs for medical faculty who instruct, supervise, and evaluate the house staff. Third, the teaching hospital incurs overhead costs for special facilities and personnel required to support the graduate medical education program. These costs are currently paid for by the medicare program and are discussed in chapters IV and XXI of the Provider Reimbursement Manual. If the teaching hospital is to continue fulfilling its educational responsibilities, these costs must be reimbursed.

Function in this environment, the teaching physician also has other objectives and responsibilities. In addition to educational, research, and administrative activities, these physicians provide special services to their private patients for which fees are billed which are financed by all third parties, including medicare part B. In order for medical schools and teaching hospitals to recruit high quality physicians for both education and service functions, the fee-for-service method of reimbursement should be available to provide adequate remuneration which compares favorably with the nonacademic practice of medicine.

House officers are involved in the care of patients of the faculty physicians. Though it is true that house officers learn from physicians caring for their private patients, the major responsibility for educating and supervising house officers is usually carried out separately by a different teaching physician. This is not a duplication of effort because the objective of the faculty physicians assigned to the teaching and supervisory function is to review selective patients in order to illustrate principles of diagnosis and therapy. This particular responsibility is not to direct the care of a specific patient, but to use the manifestation of an illness in a specific patient to initiate a general discussion of the disease entity as it presents in its various ways in different individuals. Questions have been raised concerning the extent to which a teaching physician must be involved in the care of the patient to be eligible for a medicare part B professional fee. This occurs because of the need to distinguish between the role of the teaching physician as a teacher/supervisor on the one hand and as a provider of care to his private patients on the other.

In May 1969, the Bureau of Health Insurance issued Intermediary Letter No. 372, which set forth in some detail the conditions which must be met for a teaching physician to be eligible for part B payment as an attending physician. After some initial objections over interpretation, and with some continuing misgivings about strict adherence to the letter of all of these conditions, teaching physicians are presently functioning under these requirements which, I believe, clearly separate the teaching physician's patient care role from his educational responsibilities. Some of the misgivings and interpretive problems are due to the variable enforcement efforts of the part B carriers, a point which is documented in chapter V of the IOM report.

It is important to remember that the teaching hospital—including its graduate medical education programs—is financed primarily by patient revenues and reimbursement. This single source of revenue increases the vulnerability of a critical component of the medical education continuum to reductions in reimbursement. Interest in maintaining the excellence of medical education must include a deep concern for the financial integrity of the teaching hospitals and teaching physicians, the adequacy of the reimbursement for medical services on which they are dependent, and the adequacy of reimbursement for graduate medical education program costs. I also ask you to remember that many teaching hospitals, including our own New York hospital, serve large medically indigent populations. For services provided to these individuals we are frequently inadequately paid, or not paid at all. Those who would alter existing patterns must insure that reimbursement changes do not preclude teaching hospitals from fulfilling their patient care and medical education responsibilities.

At this point, I shall ask Dr. Thompson to further elaborate on the financing of physician services for the conduct of teaching and instruction in graduate medical education programs.

Thank you.

Mr. COTTER. Proceed.

TEACHING HOSPITALS: ASSURING ADEQUATE SUPPORT

Dr. THOMPSON. The association finds the fee-for-service based recommendation of the IOM study group seriously deficient and open to question. As the recommendation is presented in the report, the fee-based method would continue to pay for professional medical services from medicare part B so long as the teaching physician provides a personal and identifiable service. However, the report sets forth the following guidelines regarding administrative, supervisory and teaching functions reimbursement under part A:

> Phasing out cost-reimbursement for supervisory and teaching services in teaching hospitals where fees are paid, over a 2-year period at the rate of 50 percent per year. At the close of the 2-year period, no cost-reimbursement would be allowed for:
>
> Supervision or teaching of house officers, except the director of medical education as noted below:
>
> Regular or routine teaching physician services on general care nursing units; and
>
> Administrative services of teaching physicians, except where there is a written agreement defining the specific services to be performed; for example, director of medical education, administration of a pulmonary function laboratory, cardiac catherization laboratory, or the like.

As stated, cost reimbursement would pay for the administrative services where provided under written agreement. However, no provision is made to pay for physicians' services for the conduct of teaching and instruction in medical education programs.

Current medicare policy on this matter is stated as follows in chapter XXI of the Provider Reimbursement Manual.

> The portion of the physician's activities representing services which are not directly related to an identifiable part of the medical care of the individual patient is the provider component. Reimbursement for provider component services can be made only to a provider on the basis of this allowable reasonable costs. Provider services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds) administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physician's provider service

> activities. Reimbursement for such services will always be made on a reasonable cost basis, under part A, where they relate to inpatient services. Reimbursement is under part B for outpatient services and for inpatient ancillary services where part A coverage has been exhausted.

The recommendation as stated by the study group would disallow some portion of above-stated reimbursement for these physician services although the language in the report is not specific enough to determine precisely those activities which would be disallowed.

For example, it is stated that the position of director of medical education would be reimbursable. In many teaching hospitals this specific position does not exist; the functions of this position are assumed by individual service or education chiefs. Presumably, since these physicians perform these activities, their services and time would be reimbursed under medicare part A; however, the interpretation is not clear. Beyond this point, it is made definite that teaching services of any other physician (who is not a service chief or director of medical education) would not be reimbursed. Current medicare policy on this issue is addressed in point 5, page 4, of Intermediary Letter No. 372, as follows:

> Where payment is made under part B on a reasonable charge basis, payment may not also be made on a cost basis to the hospital for the same services as a teaching service.

Stated here is the concept that a teaching physician who engaged house officers and medical students in the care of his patients would not be paid part A salary dollars for teaching at the same time he is being paid a fee to provide professional medical services to patients.

It should be made clear here that the current patterns of graduate medical education include time spent by teaching physicians with patients who are not their patient. These kinds of teaching rounds in addition to the case presentation, seminars, and lectures are instruction and educational time devoted to graduate medical education for which the teaching hospital needs to be reimbursed. Here lies the subtle heart of the allegation of "double billing" which has been evident ever since the controversy began which resulted in the IOM study.

There is no attempt made to define this allegation in the IOM study. The closest the report comes to addressing this issue directly is a quotation on page 14, which states:

> Since shared responsibility is the basis of graduate medical education, the issue of medicare reimbursement for teaching physician services has focused, since 1969, on a definition of the circumstances under which a teaching physician may be paid a fee for his medical services which does not duplicate other reimbursement.

The elusive question which is causing the controversy should be stated as follows: How can one be reasonably certain that time and effort devoted to and reimbursed under medicare part A for administration, supervision, and teaching does not simultaneously include professional medical services which are billed under medicare part B?

This states the problem more clearly than did the study group and further suggests that the issue is a medicare and institutional management problem rather than a policy problem.

The association is strongly opposed to double billing in which a single service is reimbursed simultaneously under both part A and part B. Where reimbursable professional medical services and educational services are simultaneously provided as a joint and inseparable product by a faculty physician, the faculty physician should receive payment for the professional medical services only. Where the faculty physician is providing educational support and supervision which is separate and distinct from the patient's direct medical care services, payment under part A should support the faculty physician.

What is needed, therefore, is a management control procedure which identifies, differentiates, and records educational supervision provided jointly and inseparably with professional medical services as distinct from educational supervision provided separately and independently of professional medical services.

In developing this reporting procedure, it would be reasonable to assume that a faculty physician could not perform separate and distinct educational supervision on patients for whom the same faculty physician has attending or formal consultative responsibility. The required procedure needs to identify educational supervision where faculty physician A is supervising residents who are participating in the care of patients with physician B. Unfortunatley, the IOM study contributed very little to the development of such a managerial control procedure.

The Association of American Medical Colleges has consistently supported a policy which would finance graduate medical education from the institutionally generated health care dollar. This policy includes the financing of the teachers—supervising physicians—as well as the house officers. Where the individual institution develops the above prescribed procedure, the association recommends that the teaching time of the supervising physician be allowed as a reimbursable cost.

I think Dr. Buchanan's observations and the points I have made illustrate the pattern of financing and organizing graduate medical education that medical schools and teaching hospitals have fashioned to provide programs producing graduate physicians. We believe this approach in concept is both equitable to all concerned and assures proper recognition of the crucial educational function. I should say, however, that this financing is increasingly less than stable, and any precipitous action could indeed have very serious implications for these important national programs.

COST-BASED METHOD OF PAYMENT

The association does not object, per se, to an exclusively cost-based method of reimbursement as an option if it recognizes and provides appropriate compensation for all three types of physicians' services which are present in teaching hospitals. However, the association is unable to endorse the IOM recommendation on cost-based reimbursement because of the substantial ambiguities contained within the recommendation. The definition of "cost" which the Institute of Medicine is recommending is unclear. The recommendation would be acceptable if cost is to be defined to mean the full and complete costs, including facility, clerical, and overhead reimbursement required to support and sustain a physician within the teaching hospital and which insures that medicare will pay its proportionate fair share of these costs. If other definitions are used or intended for the IOM recommendation, the cost-based method of reimbursement will leave unreimbursed some physician or hospital costs which are legitimately incurred.

As an example of one of these issues, appendix A to this testimony includes technical discussion of an apportionment problem which I hope will receive your staff's attention. For the association to evaluate fully the IOM recommendation for cost-based reimbursement these issues of cost definitions and voluntary physicians must be clarified.

As the subcommittee and its staff continue to address the issues in the IOM report, the association would be pleased to provide constructive comments and suggestions.

Thank you for permitting us to testify before you this morning. We will be happy to address any questions you may have.

[Attachments to the prepared statement follow:]

APPENDIX A

The aggregate per diem method comprises the current procedures by which teaching hospitals are reimbursed for physicians' direct medical and surgical services on a cost basis under regulations published by the Social Security Administration's Bureau of Health Insurance. The following example serves to illustrate the calculation procedures.

Suppose a facility which chose to utilize the cost approach expended one-million dollars for physician salaries. The combined effort reports of these physicians indicate that sixty percent of their time is devoted to inpatient services and forty percent is spent in the outpatient department. In both the inpatient and outpatient areas, these physicians spend eighty percent of their time in direct medical or surgical service, and twenty percent of their time in administration and supervision.

Further assume that this facility provides 100,000 days of inpatient care[1] and 320,000 occasions of service in the outpatient and emergency departments. Twenty percent of the inpatient days and ten percent of the outpatient and emergency occasions of service are provided to Medicare beneficiaries. In order to determine the rate at which Medicare would reimburse for the direct medical and surgical services, the following calculations must be made:

1. Twenty percent of the million dollars ($200,000) representing supervision and administration is subtracted and introduced into the cost report for normal allocation and step-down. The remaining $800,000 is then utilized as the base salary figure to begin calculation of the "aggregate per diem" physicians' professional service rate.

2. (a) Inpatient percentage of effort equals $800,000×60% or $480,000.
(b) Outpatient percentage of efforts equals $800,000×40% or $320,000.[2]

3. Rate per unit of service is then calculated as follows:

$$\frac{\$480{,}000\ \text{(inpatient salary component)} + \$320{,}000\ \text{(outpatient salary component)}}{100{,}000\ \text{(days)} + \dfrac{320{,}000\ \text{(occasions of service)}}{\text{1.2 factor [3]}}}$$

$$\frac{\$800{,}000}{100{,}000+266{,}666} = \frac{\$800{,}000}{366{,}666} = \$2.18$$

4. Each Medicare inpatient day and outpatient or emergency "visit day" is then reimbursed at the rate of $2.18.

5. Medicare's reimbursement share is then calculated as follows:

20,000 inpatient days×$2.18	$43, 600
26,666 outpatient visit days×$2.18	(58, 132)
$58,132×80 percent coinsurance	46, 506
Total reimbursement equals	90, 106

---

[1] Including an additional factor of 3½ days for each admission.

[2] In calculating the aggregate per diem rate there is no need to split the inpatient and outpatient effort; it is included here since it is necessary to refer to it later in this discussion.

[3] A factor of 1.2 has been used by BHI to transform "occasions of service" to "visit days" since "visit days" is the statistic required by BHI for the calculation.

It should be noted that if the rates for inpatient and outpatient services are calculated *separately* instead of aggregated a *substantially different* result obtains. Separate calculations would be made as follows:

$$\text{Inpatient reimbursement} = \frac{\$480{,}000 \text{ (inpatient salary component)}}{100{,}000 \text{ days}} = \$4.80$$

$$\text{Outpatient reimbursement} = \frac{\$320{,}000 \text{ (outpatient salary component)}}{320{,}000 \text{ occasions of service}} = \text{----------} \$1.00$$

Medicare's reimbursement share is then calculated as follows:

20,000 inpatient days × $4.80	$96,000
32,000 occasions of service × $1.00	(32,000)
32,000 × 80 percent coinsurance	25,600
Total reimbursement equals	121,600

This total of $121,000 reimbursement is $31,494 higher than would be reimbursed under the aggregate per diem method.

This difference in reimbursement is essentially due to two factors—Medicare inpatient and outpatient volume and the fact that the aggregate method does not allow for physician time or effort determination between inpatient and outpatient activities. A review of statistics compiled by providers which are using Part A reimbursement for physicians' professional services would most likely reveal greater than fifty percent effort by physicians for inpatient services and a larger absolute number of Medicare outpatient occasions of service. The combination of these two facts under the aggregate per diem method has served to penalize, financially, teaching hospitals which are on a cost basis for teaching physician professional medical and surgical services.

This information and set of arguments were communicated by correspondence with the Bureau of Health Insurance on June 16, 1975. An answer, unresponsive to the questions raised, was received on August 4, 1975. Repeated efforts since that time to arrange a meeting to discuss the matter have been unsuccessful.

Institute of Medicine—Social Security Studies: Comments Prepared by the Association of American Medical Colleges, June 1976

The Association of American Medical Colleges (AAMC) has carefully studied the final report of the Institute of Medicine's "Medicare and Medicaid Reimbursement Study" published in March of 1976, and believes that its comments on the study and recommendations can contribute to the continuing consideration of the important and complex set of issues involved. The Association represents all of the nation's medical schools, 400 of the nation's major teaching hospitals, and 60 academic societies. Thus, the recommendations of the IOM study on payment for physicians in teaching hospitals, the specialty and geographic distribution of physicians, and foreign graduates are of direct and significant interest to the Association's members and have far-reaching implications for their programs.

In undertaking the study, the Institute of Medicine was presented with a large and difficult challenge. It is a tribute to the dedication and diligence of the IOM staff that this study has been completed in a timely fashion. The Association is fully aware of the rigorous study plan developed by the IOM staff. The national questionnaire survey of the nation's teaching hospitals when combined with the site visits to medical schools and teaching hospitals, and the intermediary and carrier surveys have brought together substantial and important information on the organization and operation of teaching hospitals, medical schools, and graduate medical education in the United States. The extensive literature reviews on the specialty and geographic distribution of physicians and the discussion in the expert panels which were convened, provide comprehensive documentation of the limited knowledge in two issues that are of increasing public concern.

The Association is impressed with the expertise and integrity of the members of the Steering Committee and the Advisory Panels on Teaching Hospitals, Specialty and Geographic Distribution of Physicians, and Foreign Medical Graduates. All of these individuals, we are certain, have made important and substantial contributions to the Report.

The recommendations contained in the IOM Report provide the organizing focus for the Association's response to the study. Before beginning a point-by-point discussion of these recommendations, however, the Association wishes to recognize the depth and quality of the resource papers included in the

March 1976 edition of the Report. These resource papers are a significant and scholarly introduction to those with limited background on the issues analyzed. While not endorsing every statement in the resource papers, the Association commends the IOM staff on the high quality of its efforts.

The Association's response to the recommendations of the IOM Study is organized into the following separate sections:

(1) The specialty and geographic distribution of physicians;

(2) Foreign medical graduates;

(3) Alternative reimbursement methods for paying physicians in the teaching hospital setting; and,

(4) Additional delay in Section 227 implementation.

THE SPECIALTY AND GEOGRAPHIC DISTRIBUTION OF PHYSICIANS

The 1973 amendments to the Social Security Act directed the Secretary of Health, Education, and Welfare to arrange for a study concerning: (1) "the extent to which funds expended under such titles (XVIII and XIX) are supporting the training of medical specialties which are in excess supply;" and, (2) "how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty."

Specialty distribution

Data contained in the IOM Report (Table 2 of Chapter 2) demonstrate significant trends in the growth of "contact" specialty graduate medical education opportunities. Between 1970 and 1974 the survey data identified specialty growth as follows:

	New positions
Contact specialties [4]	6,028
Surgical specialties	3,993
Medicine and pediatric subspecialties	898
Other specialties	2,459

[4] The Report introduces the term "contact physicians." These include general practitioners, family practitioners, general internists, and general pediatricians.

Forty-five percent of new residency positions during the four-year period were in the "contact" specialties. The remaining 55 percent of new residency positions were divided among the more than twenty other specialties and subspecialties.

These findings are verified and amplified by inspection of data derived from the National Intern and Resident Matching Program, which will be published in the near future by its Executive Vice President, Dr. J. S. Graettinger.[5]

TABLE I.—GME-I POSITIONS OFFERED THROUGH NIRMP

	1974		1975		1976	
	Number	Percent	Number	Percent	Number	Percent
Contacts pecialties:						
General practice	67		58		68	
Family practice	1,016		1,362		1,637	
Internal medicine	4,347		4,845		4,971	
Pediatrics	1,380		1,450		1,576	
Total	6,810	(39)	7,715	(49)	8,252	(51)
Obstetrics-gynecology	595		804		808	
Contact plus obstetrics-gynecology	7,405	42	8,519	54	9,060	56
General surgery	2,452		2,497		2,417	
Surgical specialties	372		721		752	
Total surgery	2,824	16	3,218	20	3,169	20
All other disciplinary programs [1]	1,509	9	1,915	12	2,125	13
Rotating/Flexible	5,665	33	2,039	13	1,757	11
Total positions available	17,403	100	15,891	[2] 99	16,112	100

[1] Psychiatry, radiology, pathology, medical specialties.
[2] Does not add due to rounding.

---

[5] Graettinger, J. S. "Graduate Medical Education Viewed from the National Intern and Resident Matching Program," *Journal of Medical Education* (in press), 1976.

This table illustrates that the positions offered in "contact" specialties increased from 6,810 in 1974 to 8,252 in 1976. This increase of 1,442 new positions is four times the increase in surgery and two times the increase in other disciplinary programs. Undoubtedly, the redistribution of GME–1 positions amongst various program categories has been, in part, because of the decline in flexible/rotation internship positions. However, it is important to note that the institutions in adjusting to a declining emphasis on rotation/flexible programs have opted in the main to utilize their resources to develop "contact" specialty positions.

TABLE II.—FIRST GRADUATE YEAR POSITIONS OFFERED THROUGH NIRMP VERSUS TOTAL U.S. GRADUATES

	1970	1971	1972	1973	1974	1975	1976
Positions offered	15, 567	16, 515	17, 283	18, 721	17, 403	15, 961	16, 112
U.S. graduates	8, 367	8, 974	9, 551	10, 391	11, 365	12, 714	13, 505
Positions offered ÷ U.S. graduates (×100) (percent)	185	184	180	180	153	125	119

Table II further demonstrates that redistribution is occurring rather than the simple addition of contact specialty programs to the number of programs previously offered. There are only 526 (3%) more positions available in 1976 than were available in 1970. Comparing GME–1 positions available with the rising number of students graduating from U.S. medical schools demonstrates that the often-decried surplus of residency positions in the United States is rapidly changing toward a potential shortage of sufficient positions to provide graduate training opportunities for U.S. graduates. If the current trend toward zero growth in graduate programs continues, by the time the class of 15,295 students who entered medical school in 1976 graduates, there will be only 9% more positions available than graduates. By that time, the graduate medical capacity of this country will be saturated, and may be overtaxed. Because graduate medical education is essential to educating physicians, policies not only to modify specialty distribution but also to increase graduate medical education opportunities are needed. The Institute of Medicine report does not provide a needed emphasis to this rapidly approaching crisis.

TABLE III.—U.S. GRADUATING STUDENTS MATCHED THROUGH NIRMP

	1974		1975		1976	
	Number	Percent	Number	Percent	Number	Percent
Contact specialties:						
General practice	0		1		0	
Family practice	801	(9)	1, 333	(11)	1, 346	(13)
Internal medicine	3, 122	(34)	3, 829	(38)	4, 071	(38)
Pediatrics	910	(10)	1, 028	(10)	1, 107	(10)
Total contact	4, 833	(53)	5, 991	(60)	6, 524	(61)
Obstetrics-gynecology	291		528		575	
Contact plus obstetrics-gynecology	5, 124	55	6, 519	65	7, 099	66
General surgery	1, 386	(15)	1, 504	(15)	1, 486	(14)
Surgical specialities	78	(1)	304	(3)	328	(3)
Total surgery	1, 464	16	1, 808	18	1, 814	17
All other disciplinary programs [1]	483	5	686	7	882	8
Rotating/flexible	2, 153	23	986	10	988	9
Total U.S. students matched [2]	9, 224	[3] 99	9, 999	100	10, 783	100

[1] See table I.

[2] For 1974, this represents 79.4 percent of graduating students and for 1975, 78.6 percent, and for 1976, 79.8 percent. Students not matched in the NIRMP either chose not to enter the plan, or failed to be matched and sought positions separately. It can be assumed that the distribution of their choice specialites is not dissimilar to the nearly 80 percent of graduating students for whom there is data.

[3] Does not add due to rounding.

The personal choices for GME–1 positions made by U.S. medical students at graduation are indicative of how the students and their institutions are responding to the national demand for more contact specialists. Table III illustrates that this response is significant.

Every year, from 1974 to 1976, in excess of 50% of U.S. students selected GME–1 positions in the contact specialties. The proportion of each class opting for contact specialties increased each year. More importantly, because of the rapid increase in total graduates, the growth in the contact specialties in absolute numbers has been large. There are 35% more U.S. students entering contact specialties in 1976 than in 1974.

All students entering contact specialty programs for their GME–1 year cannot be expected to develop careers exclusively as generalists providing primary care. Five to ten percent, having acquired a year of broad clinical training, will enter non-contact specialty programs in their GME–II year. Allowing for 7.5% attrition from the contact specialties in the 1976 match, 6,036 students are expected to stay in the contact specialties. This is 56% of the students matched.

TABLE IV.—PROJECTED ESTIMATES OF FULL-TIME EQUIVALENT CONTACT SPECIALISTS FROM THE 1976 MATCH

	Matched GME–I	Expected to complete training	Expected to subspecialize	Remaining as full "contact" specialists	Subspecialty FTE "contact" specialists	Total FTE "contact" specialists
Family medicine	1,346	1,245		1,245		1,245
Internal medicine	4,071	3,767	1,583	2,184	791	2,975
Pediatrics	1,107	1,024	169	855	42	897
Total	6,524	6,036	1,752	4,284	833	5,117
Percent [1]	61	56	16	40	8	47

[1] Percent of 10,783 U.S. students matched.

Not all students embarking on careers as internists or pediatricians will remain generalists. Projections relevant to students matched this year can only be made on data derived from students who graduated from medical school before the emphasis on primary care was as strong as at present. The American Board of Internal Medicine reports that 42% of the students who received their primary certification in 1972 sought certification for special competence in a subspecialty in 1974. The American Board of Pediatrics found that of the 600 candidates for their oral exam in 1975, 8% had had one year of subspecialty training and 8.5% had two years. In Table IV estimations of eventual FTE contact specialists are projected for the students in the 1976 match, based upon the proportions expected to subspecialize as reported by the Boards of Medicine and Pediatrics. If all subspecialists are fully engaged only in their subspecialty, 4,284 or 40% of those matched in 1976 will be providing primary care in the future.

However, internists and peditricians with subspeciality competence are not usually exclusively engaged in their subspecialty. Applying a correction of 50% subspecialty practice for internists and 75% for pediatricians provides a factor estimating subspecialists' contributions to primary care. Subspecialists in internal medicine are projected to provide 791 FTEs as primary care providers, and pediatricians, 42 FTEs. Adding these to the previous total, 5,117 FTE contact specialists are projected. This is 47% of all students participating in the 1976 match.

Based upon the foregoing commentary it should be apparent that the recommendations contained in the Institute of Medicine report must be examined from the perspective of dynamic changes in graduate medical education.

IOM recommendation

"The Steering Committee recommends that financing mechanisms be changed to provide more equitable support for ambulatory care services so that medical schools and teaching hospitals would find it easier financially to support primary care training programs. Furthermore, Medicare and Medicaid monies might be useful as an incentive to support the expansion of training specialities. The costs of residencies in the contact physician specialties should be excluded from provisions of Section 223 which place a ceiling on the allowed increase on costs to be covered by Medicare."

Implementation of this recommendation could greatly facilitate and sustain the growth of training opportunities for "contact" specialists. The IOM study report refers to the article by Dr. Graettinger to infer that all available "contact" positions are now filled. This is not a correct inference, although the number of U.S. students desiring residencies in the "contact" specialties is essentially equal to the number of positions available. In the 1976 match, 1,011 available positions in the "contact" specialties were not filled. There were 724 U.S. graduates who listed residencies in the "contact" specialties as their first choice who were unmatched. Although, the demand by U.S. medical students for first year positions in the "contact" specialties is essentially equal to the positions available, approximately one thousand of the available positions were not sought after with sufficient interest to be filled by U.S. students. Seven-hundred and seventeen positions in the "contact" specialties were filled by foreign medical graduates. However, few of these positions had any applications from U.S. students. It is believed that a significant reason for U.S. students eschewing some of the available "contact" specialty programs is because they are not considered to be sufficiently high quality. While the quality of medical education programs is determined by a large number of factors, it should be recognized that institutional attempts to develop, upgrade, and maintain programs with a standard of excellence may be substantially constrained by inadequate financial support. The provision of adequate financing, especially ambulatory care financing, will help facilitate institutional attempts to provide high quality medical education programs, including programs in the contact specialties.

Thus far, stable funding for ambulatory educational settings has not been possible. Teaching hospital based outpatient departments have long been characterized as the principal financial "loss leader" of the academic health center. A number of reasons have been set forth as causes for this situation. Among the more frequently stated causes are:

(1) Private and public insurance payment programs provide insufficient or non-existent benefit coverage for ambulatory services;

(2) Patients who are attracted to hospital outpatient department frequently have no insurance coverage or poor insurance coverage, and are unable to pay for services;

(3) Involvement of house officers and medical students in the delivery of ambulatory medical care reduces productivity, thus raising the "per visit" cost to the point where it is not fully reimbursable; and,

(4) The added educational cost, coupled with the productivity factor stated above further compounds the problem.

The emphasis on educational programs in the ambulatory setting have served to raise this particular financing issue to the forefront in the priority of problems teaching institutions are facing. State Medicaid programs are experiencing severe financial problems resulting in a lowering of eligibility standards (or at best, failing to raise them) and a "tightening" or "freeze" on reimbursement.

There has been substantial pressure and subsequent institutional commitment to provide a greater amount of educational experience in ambulatory settings to produce more primary care physicians. Generally, these commitments have been made without sufficient attention to longer-range financial consideration. For example, under the Manpower Act of 1971, a large number of family practice residency programs are being supported by Federal grant awards which finance faculty salaries and residency stipends and make it feasible to provide an ambulatory educational setting. In the absence of such awards, these programs could not financially survive.

The financing of all educational programs in the ambulatory setting is a difficult problem and one which has not received the attention it deserves. Facing continuing large deficits in the operation of their ambulatory services, and diminishing ability to cover these losses from other revenue sources, teaching hospitals cannot significantly expand their ambulatory educational and service programs without adequate reimbursement for them. Providing adequate financing of ambulatory care services to encourage and permit improvement of "contact" specialty training programs, will help maintain and continue the growth in "contact" specialty positions and students which is already in progress.

The AAMC has proposed and supported a provision in S. 3205, introduced by Senator Talmadge (D–Ga.), which would exclude specific components of "routine operating costs" so that variations of the remaining routine costs to be measured and compared under Section 223 are *not* due to the nature of the product produced or to the characteristics of the production process that cannot reasonably be altered in short periods of time. Included in the AAMC recommendations of items to be excluded from "routine operating costs" are *all* residency costs. While the IOM proposal to eliminate *only* the costs of residencies in the contact physician specialties from Section 223 ceiling determinations might at first appear to be desirable, it is in conflict with a more comprehensive proposal which would correct some of the present overall deficiencies in the implementation of Section 223 of the 1972 Social Security Amendments.

IOM recommendation

The Steering Committee recommends that direct support to medical schools and teaching hospitals be continued through special project grants. This support should also be extended to cover the other contact specialties of general internal medicine and general pediatrics where quality programs can be maintained.

The continuation of special project grants and their extension to general internal medicine and general pediatrics is strongly recommended. Special project support will help to sustain and encourage program growth and improvement.

Medical schools and teaching hospitals have become distrustful of federal initiatives which provide only for limited periods of funding through special projects. Administrators and faculty are growing reluctant to assume responsibility for the initiation of long-term medical education programs with short-term, special project financing. Although "start-up" funds for special projects are important to initiate programs, funding for the implementation of long-term training opportunities for contact physicians must be directed to fundamental reimbursement problems in providing ambulatory services as set forth earlier in addition to short-term special project funds.

IOM recommendation

A permanent quasi-public independent physician manpower commission of 13 members should be established by law to monitor the specialty distribution of physicians and to determine the appropriate number of residency slots for each specialty. The enforcement of the commission's determinations would be the responsibility of the LCGME, the CCME, and the AOA's Committee on Postdoctoral Training through extension of their respective accreditation mechanisms, to control the number of residency positions in each training program . . .

Establishing a regulatory system empowered to make and enforce decisions regarding the training opportunities to be provided in graduate medical education in the United States is such a major administrative and bureaucratic addition, that both the need for such an organization and its function should be carefully examined.

Until the trend in rapid growth in training for contact specialties was revealed by the data from the National Intern and Resident Matching Program, the Association was firmly supportive of establishing a regulatory agency empowered to designate annually the graduate medical education positions which could be filled in each specialty. The fact that students are responding to a variety of incentives to enter contact specialties illustrates that incentive measures are effective. Furthermore, regulation of positions probably cannot be achieved if the regulatory decisions are significantly diverse from trends already set in motion by other forces.

Determining the need for physicians of one specialty versus another is not subject to precise analysis. The possible policy decisions which could be made will be rather gross (as gross as the present decision that at least 50% of graduating U.S. students should select careers in the primary care specialties). Empowering a regulatory agency, whether federal, private, or quasi-public, to adjust the graduate medical education system annually through mandating the positions that can be filled may be over-response.

On the other hand, until recently little attention has been paid to the trends in graduate medical education and the congruence of these trends with physician manpower needs. An organization charged with the responsibility to monitor the trends in graduate medical education and to make policy recommendations which will influence the growth or retardation of one specialty or another is needed. Such an organization must be able to influence the physician education and teaching hospital reimbursement policies of the Congress and Executive Branch of the Federal Government. Its policy recommendations should be predominately in the direction of facilitating rather than mandating change.

The power to mandate should be used only if the voluntary facilitating mechanisms fail. Given the demonstrated responsiveness of the medical education system to change itself when the opportunity to implement needed change is facilitated through appropriate resource availability, it is unlikely that mandatory power will be needed.

The functions of the proposed organization include a basic and fundamental flaw. The Institute of Medicine recommends that the decision of a quasi-public commission be enforced through the accreditation process. The commission would decide the number of positions to be made available in each specialty, and the Coordinating Council on Medical Education and its Liaison Committee on Graduate Medical Education would be required to enforce these decisions. This is an inappropriate application of the accreditation process.

The purpose of accreditation is primarily to ensure students and secondarily to ensure interested agencies that the educational programs offered meet predetermined standards of quality. Limitations on the maximum number of training positions accredited in any program can be justified only on the basis of the resources available and used in that particular program. Distributing training positions on the basis of national need should not be accomplished through accreditation. The Liaison Committee on Graduate Medical Education can determine the maximum and minimum number of positions consistent with maintaining the educational quality of each program, but another organization must decide the specialty distribution of training positions on the basis of manpower needs. To preserve program quality, such an organization must be prohibited from exceeding the maximum-minimum limits set for each program by the LCGME.

The commission recommended by the IOM would have 13 members: six from the professional organizations involved in graduate medical education, and seven ". . . *representatives from other sectors*." The need for input from individuals outside the professional groups directly involved in graduate medical education is definitely acknowledged; however, majority representation from these "other sectors" is questioned.

In summary, there is in progress a dynamic growth of student interest in the contact specialties. This redistribution makes it doubtful that there is a need to establish an organization authorized to distribute positions in graduate medical education annually. A monitoring organization with stature and influence is needed. Furthermore, using the accrediting system to distribute positions to fulfill national manpower goals is inappropriate. It is the AAMC's position that the Coordinating Council on Medical Education can provide the monitoring and policy development functions recommended in the IOM report. Considerable resources in excess of those now available to the Coordinating Council will be necessary to accomplish these functions, and some means of ensuring that the Council's recommendations are heeded by public policy-makers is needed.

IOM recommendation

With the exception of the category of contact physicians defined as family practice, general internal medicine, and general pediatrics, the number of all other postgraduate specialty training slots available as of July 1, 1977 should be held at the level of residency positions filled as of July 1, 1975. The number of training slots for contact physicians should be expanded, with care given to ensure that the highest quality educational environment is maintained. There may be unusual circmustances which warrant an expansion of residency training slots in other than the contact specialties. Examples of these situations would include medical schools in the process of development or pending commitments to individual trainees.

Given the trends in graduate medical education already cited, the imposition of a freeze on programs and positions other than those for contact physicians is unnecessary. Furthermore, it is unworkable. IOM recommends that the Liaison Committee on Graduate Medical Education enforce this freeze. LCGME does not have the prerogative to refuse an application for review and accreditation by an institution. If an applicant institution set forth a program which on review meets accreditation standards, LCGME's action must be in the affirmative. While the purpose of a freeze would be to control the total positions available nationally in each frozen specialty, the effect would be to freeze the positions offered by each institution's program. Annually, each institution must decide how many positions it can offer within the available maximum authorized by the LCGME. There is considerable flux in these allocations from institution to institution each year, even though the national total may not change. Monitoring this flux, to ensure that the national freeze limit would not be exceeded, is beyond the present capability of the LCGME.

The NIRMP data demonstrate that between 1974 and 1976, surgical positions offered to first year students decreased by 35 positions (-1.5%) in the entire United States. During the same period contact specialty positions increased by 1,442 (13%). This trend to reduce available surgical positions and increase contact specialty positions can be expected to continue, particularly if special project support and modified ambulatory care reimbursement policies are provided. The proposed freeze appears to be unnecessary; further, the administrative complexities introduced could impede the already established trend.

IOM recommendation

A major study should be undertaken to re-examine the basis of physician fees and the fee allowance in public and private health insurance programs.

This recommendation raises an important issue that has not been sufficiently examined. The prevailing wisdom holds that physician specialty distribution in the United States is predominantly the responsibility of the medical education system. Those who find fault with specialty distribution have vociferiously blamed the medical schools and teaching hospitals, and have attempted to change these institutions toward whichever specialty mix is currently popular.

The IOM wisely suggests that the reimbursement policies of Medicare-Medicaid and the fee schedules derived therefrom may have some influence on the career choices made by physicians. Modified fee schedules for practicing physicians need to be considered so that comprehensive, continuing care is more equitably rewarded than at present. Current fee schedules appear to place the greatest reward on short-term technical interventions in acute disease states. Comprehensive, continuing care, which requires provision of less dramatic services by physicians and other members of the health care team, will not be achieved unless market forces provide the appropriate incentives.

GEOGRAPHIC DISTRIBUTION

IOM recommendation

The Steering Committee recommends that Medicaid practices which pay physicians at lower levels, particularly in underserved areas, be discontinued. This may be difficult to achieve, given the financial pressures faced by many state governments. Furthermore, anecdotal evidence on the disproportionate billing and administrative expense often associated with collecting Medicaid fees suggests that a detailed examination of Medicaid administrative practices should be undertaken to document the extent to which these practices affect the availability of physician services in underserved areas.

The report divided influences affecting geographic distribution of physicians into "economic" and "other." In the "economic" category, IOM specifically recommends modification of Medicare-Medicaid policies which might increase the number of physicians serving in underserved rural and inner-city areas. The recommendation to discontinue policies which pay for services to Medicaid patients at lower levels than other patients is important. A medical care system with two standards of care is unacceptable in the United States. Reimbursement policies and practices which stigmatize caring for patients dependent on Medicare are unacceptable; and unless corrected, such policies and practices will retard the recruitment of physicians into underserved areas. Reversal of present Medicaid policies would also allow medical schools and teaching hospitals to improve their educational settings and teaching programs. These institutions provide a large proportion of medical services to indigent populations, particularly in inner-city, metropolitan areas.

In the "other" influences category, the report acknowledges that choices of a geographic area are subject to many social and cultural influences which are not susceptible to direct intervention. IOM recommends that student selection policies for admission to medical school should take into account students' geographic preferences. IOM encourages the development of educational experiences in remote sites away from the main medical school campus. The experimental development of area health education centers is considered as promising and worthy of continuation by IOM. Facilitation of the development of group practices by young contact physicians seeking to locate in rural areas is also recommended, and the provision of resources for such physicians to establish group practices with needed support personnel and appropriate facilities is endorsed.

There is no firm evidence that the IOM's recommendations and suggestions for modifying geographic distribution will be effective. However, the recommendations which the academic centers are currently developing, are worthy of further trial and evaluation.

FOREIGN MEDICAL GRADUATES

The IOM study was charged with examining "the extent to which such funds (Medicare and Medicaid) support or encourage training programs which tend to disproportionately attract foreign medical graduates." The study group found no relationship between the extent of Medicare and Medicaid funding and a disproportional number of FMGs. In other words, hospitals and programs with both low and high proportions of FMGs are found equally in low and high Medicare/Medicaid recipient categories. Similarly, no consistent difference was found in activities by house staff in relationship to a high or low proportion of FMGs. Thus, the report seems to have documented that Medicare and Medicaid reimbursement policies are not serving to support or encourage training programs which disportionately attract foreign medical graduates.

IOM recommendation

In view of the decreasing number of positions likely to be available for foreign medical graduates and the possibility that future medical graduates may not be able to get the graduate medical education necessary for full licensure in this country, the steering committee recommends the elimination of existing incentives for physician immigration, including the removal of medicine as a shortage profession under the Department of Labor's Schedule A.

The Association supports this recommendation. The Association would like to make it absolutely clear, however, that rather than using unfilled house staff positions to determine the requirements for graduate medical education, the Association advocates determining the requirements for graduate medical education on the actual need for physicians to provide professional medical services and to carry out biomedical research.

Without contradicting the IOM recommendation that existing incentives for physician immigation be eliminated, the Association recommends that the foreign exchange visitor's program be re-established to serve its original purpose, mainly to train physicians for service in their own developing countries and not for service in the United States. To accomplish this, the Association recommends the following: (1) sponsorship of FMGs in foreign exchange programs should be limited to accredited schools of the health professions together with their affiliated teaching hospitals; (2) visitor exchange programs should be arranged by agreement with the United States Government and the governments of other countries and their respective institutions for our medical education system to provide specific types of training for individual physicians designated to fulfill key roles in their countries; (3) such candidates must meet the standards of professional preparation established by U.S. institutions and accrediting agencies and must be committed to return to their home country. They must have sufficient knowledge of the English language to carry out their anticipated program; (4) the duration of the program should be specified in advance; usually two-years or less. Extension should only be granted upon request by the sponsors both in their home country and in the United States.

ALTERNATIVE REIMBURSEMENT METHODS FOR PAYING PHYSICIANS IN THE TEACHING HOSPITAL SETTING

Teaching hospitals, which by definition in the study are those that serve as the site for graduate medical education programs, have three separate and distinct types of physicians' services provided within the institution. First, there are physician activities which comprise the direct and personal medical services provided to both inpatients and outpatients. Second, there are physicians services required for the administration and supervision of the hospitals as a organization—its organizational components and its special programs. Third, there are physician services for the conduct of teaching and instruction in the medical education programs.

Fee-based method of payment

The Association finds the fee-for-service based recommendation of the study group seriously deficient and open to question. As the recommendation is presented in the report, the fee-based method would continue to pay for professional medical services from Medicare Part B so long as the teaching physician provides a personal and identifiable service. However, the report sets forth the following guidelines regarding administrative, supervisory and teaching functions reimbursement under Part A:

> Phasing out cost-reimbursement for supervisory and teaching services in teaching hospitals where fees are paid, over a two-year period at the rate of 50 percent per year. At the close of the two-year period, no cost-reimbursement would be allowed for:
>
>> Supervision or teaching of house officers, except the director of medical education as noted below;
>>
>> Regular or routine teaching physician service on general care nursing units; and
>>
>> Administrative services of teaching physicians, except where there is a written agreement defining the specific services to be performed; for example, director of medical education, administration of a pulmonary function laboratory, cardiac catherization laboratory, or the like.

As stated, cost reimbursement would pay for the administrative services where provided under written agreement. However, no provision is made to pay for physicians' services for the conduct of teaching and instruction in medical education programs.

Current Medicare policy on this matter is stated as follows in Chapter 21 of the Provider Reimbursement Manual:

> The portion of the physician's activities representing services which are not directly related to an identifiable part of the medical care of the individual patient is the provider component. Reimbursement for provider component services can be made only to a provider on the basis of its allowable reasonable costs. Provider services include teaching, research conducted in conjunction with and as part of patient care (to the extent that such costs are not met by special research funds), administration, general supervision of professional or technical personnel, laboratory quality control activities, committee work, performance of autopsies, and attending conferences as part of the physician's provider service activities. Reimbursement for such services will always be made on a reasonable cost basis, under Part A, where they relate to inpatient services. Reimbursement is under Part B for outpatient services and for inpatient ancillary services where Part A coverage has been exhausted.

Again, the recommendation as stated by the study group would disallow some portion of reimbursement for these physician services, although the language in the report is not specific enough to determine precisely those activities which would be disallowed.

For example, it is stated that the position of director of medical education would be reimbursable. In many major teaching hospitals this specific position deos not exist; the functions of this position are assumed by individual service chiefs. Presumably, since these physicians perform these activities, their services and time would be reimbursed under Medicare Part A; however, the interpretation is not clear. Beyond this point, it is made definite that teaching services of any other physician (who is not a service chief or director of medical education) would not be reimbursed. Current Medicare policy on this issue is addressed in point five, page four, of Intermediary Letter No. 372 as follows: "Where payment is made under Part B on a reasonable charge basis, payment may not also be made on a cost basis to the hospital for the *same services* (italics supplied) as a teaching service." Stated here is the concept that a teaching physician who engaged house officers and medical students in the care of his patients would not be paid Part A salary dollars for teaching at the same time he is being paid a fee to provide professional medical services to patients.

It should be made clear here that the current patterns of graduate medical education include time spent by teaching physicians with *patients who are not their patients*. These kinds of teaching rounds in addition to the case presentations, seminars, and lectures are instruction and educational time devoted to graduate medical education for which the teaching hospital needs to be reimbursed. Here lies the heart of the allegation of "double billing" which has been evident ever since the controversy began which resulted in the IOM study.

There is no attempt made to define this allegation. The closest the report comes to addressing this issue directly is a quotation on page 14 which states, "Since shared responsibility is the basis of graduate medical education, the issue of Medicare reimbursement for teaching physician services has focused, since 1969, on definition of the circumstances under which a teaching physician may be paid a fee for his medical services which does not duplicate other reimbursement."

The subtle and sometimes elusive question which is causing the controversy should be stated as follows: "How can one be reasonably certain that time and effort devoted to and reimbursed under Medicare Part A for administration, supervision and teaching does not *simultaneously* include professional medical services which are billed under Medicare Part B." This states the problem more clearly than did the study group, and further suggests that the issue is a *management* problem rather than a *policy* problem.

The Association is strongly opposed to double billing in which a *single* service is reimbursed under both Part A and Part B. Where reimbursable professional medical services and educational services are simultaneously provided as a joint and inseparable product by a faculty physician, the faculty physician should be reimbursed for the professional medical services only. Where the faculty physician is providing educational support and supervision which is separate and distinct from the patient's medical care services, reimbursement under Part A should support the faculty physician.

What is needed, therefore, is a managerial control procedure which identifies, differentiates and records educational supervision provided jointly and inseparably with professional medical services from educational supervision provided separate and distinct from professional medical services. It would, therefore, be reasonable to assume that a faculty physician could not perform separate and distinct educational supervision on patients for whom that same faculty physician has attending or formal consultative responsibility. Thus, the required procedure needs to identify educational supervision where faculty physician A is supervising residents who are participating in the care of patients with physician B. Unfortunately, the IOM study contributed very little to the development of such a managerial control procedure.

There are those who would suggest that since the activities of the house officer are reimbursed under Medicare Part A and the medical services of the teaching physician under Medicare Part B, such an arrangement constitutes "double billing." It should be highlighted that the financing of house officers is covered in Chapter IV of the Medicare *Provider Reimbursement Manual* entitled, "Cost of Educational Activities." The title of this chapter is most important, and needs emphasis. These costs are institutional educational costs and must be viewed in this context. Once this policy is clear, the subsequent policy determination follows. That is, if the teaching physician meets all the requirements for providing personal and identifiable patient services, a Part B fee is justified; the involvement of the resident in the service is necessary to provide for the education of future physicians, and should therefore be viewed as an educational cost.

The Association of American Medical Colleges has consistently supported a policy which would finance graduate medical education from the institutionally generated health care dollar. This policy includes the financing of the teachers—supervising physicians—as well as the house officers. Where the individual institution develops the above prescribed procedures, the Association recommends that the teaching time of the supervising physician be allowed as a reimbursable cost.

An additional important problem which needs to be recognized in the context of this recommendation is the statement that: "Mixed and geographic settings for different payment methods within a hospital would not be recognized." The objective of this recommendation is the laudable goal of achieving a single standard of high quality patient care. Alternative organizational arangements are capable of providing that single standard of care. A fully salaried staff reimbursed under Part A can provide the desired standard of care. Likewise, a voluntary staff reimbused under Part B can provide a desired standard of care. Neither of these alternative needs to be adopted throughout the hospital to ensure a single standard of care. One alternative may be adopted in some pavilions or in some wards and the other alternative is adopted in other pavilions or on other wards. Therefore, the Association recommends that the IOM recommendation be changed to state, "Mixed settings for different payment methods on a single ward will not be recognized.

Cost-based method of payment

The Association does not object, per se, to an exclusively cost-based method of reimbursement which recognizes and provides appropriate compensation for all three types of physicians' services which are present in teaching hospitals. However, the Association is unable to endorse the IOM recommendation on cost-based reimbursement because of the substantial ambiguities contained within the recommendation. The definition of "cost" which the Institute of Medicine is recommending is unclear. The recommendation would be acceptable if cost is to be defined to mean the full and complete costs including facility, clerical, and overhead reimbursement required to support and sustain a physician within the teaching hospital. If other definitions are used or intended for the IOM recommendation, the cost-based method of reimbursement will leave unreimbursed some physician or hospital costs which are legitimately incurred.

For the Association to evaluate fully the IOM recommendation for cost-based reimbursement these issues of cost definitions and voluntary physicians must be clarified.

DELAY IN IMPLEMENTATION OF SECTION 227

The Institute of Medicine study recommends that "Section 227 of Public Law 92–603 should not go into effect on July 1, 1976." Legislation delaying this implementation date until October 1, 1977, has been passed by the Congress. The reimbursement alternatives recommended by the IOM study which have been discussed in the Association's response will require significant change in some segments of the medical education community. To maintain the stability of medical schools and teaching hospitals and the quality of graduate medical education while these recommendations are evaluated, the Association supports delaying the implementation of Section 227 of Public Law 92–603 until October 1, 1977; by that time the IOM staff, the pertinent legislative committees and their staffs and the other parties at interest should have come to an equitable resolution of the issues using the IOM report as a basis for discussion and action.

Mr. Rostenkowski (presiding). Thank you, Doctor. We look forward to working with you and examining your recommendations as we delve into this report. Mr. Tierney, who preceded you, said he would like to see medical education costs handled separately from patient care reimbursement. In contrast, you want medicare payment to be made for teaching of doctors even when he is not teaching or working on his own patient or the patient is not involved. Why should we follow your recommendations and not that of Mr. Tierney?

Dr. Thompson. I think the problem, Mr. Chairman, is the difficulty in separating out these activities, as others have pointed out earlier. In the course of the care of the patient where the house officer and the teaching physician is involved, they are clearly going on simultaneously—the educational activities as they relate to the house officer and the care of the patient.

Now, it seems to me, since that is a fact and they are indeed inseparable in most instances, whichever way you provide it you are going to have that problem. It is not something that can be cleanly separated. At the present time, it is a part of the health care dollar, if you will, payment and it seems to me that it should continue to be there, inasmuch as it is there at the present time and you have the same problem no matter where you put it in my estimation.

Mr. Rostenkowski. Would you like to comment on that, Dr. Buchanan?

Dr. Buchanan. I agree.

Mr. Rostenkowski. Mr. Cotter?

Mr. Cotter. Thank you, Mr. Chairman. You have been critical that the IOM study did not suggest a management control procedure, I do not know if you were in the audience when I questioned the other witnesses, but what type of mangement control procedure would you recommend where you can differentiate between teaching and physician services?

Dr. THOMPSON. I think you may have general guidelines which could be applied to this but I think, as was pointed out in the study, the settings in which the graduate medical education program are carried out vary widely and it is difficult, therefore, to say that any single system would work. However, I think within the individual institutions, it is quite possible to make these distinctions. I think that the manner in which I. L. 372 spelled out the identifiable services to private patients and section 227 which modifies that, makes it rather clear that what is required to state that this is indeed a private patient physician relationship for which a bill can be rendered—with that, on the one hand, and the manner in which the educational function is conducted in relation to house staff, which has to do with the matter of making attending rounds with the house staff, generally speaking, on the actual unit where patients are being cared for.

On the other hand, within the institution you can make the allocation of effort relating to that function. Now, clearly, these have to be auditable and have to be understandable, that in my estimation that differentiation can be made.

Mr. COTTER. Would it not be an administrative nature, though?

Dr. THOMPSON. Well, it is not easy, but, on the other hand, with the concerns that you have and others have with regard to that, we, in the institutions, I think, have a job to set up the administrative structure to do it. We are not unfamiliar with effort reports in other situations and this is another example of where we must have accurate effort reporting.

Mr. COTTER. Do you feel then it could be accomplished?

Dr. THOMPSON. Yes, I do.

Mr. COTTER. Thank you. That is all I have.

Mr. ROSTENKOWSKI. Thank you, Doctor, and Doctor Buchanan. I want to thank all witnesses participating this morning and I know we will look forward to further discussion as we try to implement a rational policy for paying physicians in these unique medical facilities. The committee stands adjourned.

[Whereupon, at 10:45 a.m., the hearing was adjourned.]

[The following was submitted for the record:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

REIMBURSEMENT OF PHYSICIANS IN TEACHING HOSPITALS

Mr. Chairman and members of the subcommittee, the American Hospital Association, representing some 7,000 member hospitals, including most of the nation's 1,500 teaching hospitals, is pleased to present its views on the findings and recommendations contained in the study conducted by the Institute of Medicine on the issue of Medicare and Medicaid reimbursement policies as they relate to teaching physician services, specialty and geographic distribution of physicians and foreign medical graduates.

In undertaking the study, the Institute of Medicine was presented with a difficult task. The Institute should be commended for completing the assignment in a timely and effective manner. Furthermore, despite the fact that specific legislation on this issue probably cannot be developed in this session of Congress, we believe that consideration of this matter now enhances the potential for development of effective solutions.

The American Hospital Association has carefully studied the recommendations made in the report and appreciates the opportunity to submit comments that it believes can contribute to your consideration of the recommendations and the ultimate resolution of the problems. Our comments will be organized on the basis of the recommendations in the report.

PAYMENT FOR TEACHING PHYSICIAN SERVICES IN TEACHING HOSPITALS

As the Institute of Medicine has concluded, payment for teaching physician patient care services in teaching hospitals is a complex issue. Because of the variability in the circumstances the report recognizes that no payment method can achieve satisfactory results in all settings.

With one reservation the American Hospital Association concurs with Recommendation 1 whereby the elective cost reimbursement payment method currently in effect under Section 10 of Public Law 93–233 would be continued. The definition expressed on page 3 of Chapter Six suggests that cost is limited to "direct physician services," while the specific recommendation refers to "full costs." We suggest that the definition be clarified to mean full and complete costs including indirect (overhead) costs required to support the teaching physicians within teaching hospitals. If the definition is to be limited to direct costs, then this method will result in under reimbursement for certain other costs incurred by the hospital in support of the physicians. For example, costs associated with the personnel support and physical space requirements should be reimbursable. Failure to recognize indirect costs would mean payment of less than cost. We believe this is not the intent of the IOM study and we would hope that a clarified definition would include indirect costs.

The unified method of payment is discussed as both a regular payment recommendation (Recommendation 2) and as an experimental recommendation (Recommendation 4). The Association believes that the experimental recommendation is more appropriate. Permitting the unified method to be utilized as an experiment will allow for the identification of those circumstances under which that system might be appropriately applied. We would hope that this would insure that the charge developed is reasonable; that both the patient care and direct and indirect education costs are covered; and that an understanding on how the payments would be distributed among the various parties involved would be resolved (the teaching physicians, the physicians-in-training and the institution).

While the American Hospital Association supports retention of fee-based reimbursement as a method of payment for teaching physician patient care services under the existing Medicare Part B concept, we have serious concerns about some of the recommendations for modifying the present rules. Specifically, the deletion of reimbursement for supervisory and teaching services under Medicare Part A would result in a loss of payment, preventing adequate reimbursement to cover educational costs in many institutions. Payment of some physicians who are heavily involved in teaching and relatively little or not at all in the provision of care to their own patients is largely dependent on reimbursement for educational services under Part A to the hospital.

Recommendation 3 states that the costs associated with the position of director of medical education should be reimbursable under Part A. There is no such position in many teaching hospitals. Rather, the function is assumed by many individuals (e.g., service chiefs). It would appear that reimbursement for educational services in those institutions which do not employ a full-time director of medical education would be denied.

A fundamental concern underlying the recommended changes to the free-based payment method lies in the IOM's concept of "double billing." The IOM seems to suggest that, because the costs of house staff are reimbursable under Medicare Part A and the teaching physician is reimbursed under Medicare Part B for personally identified patient care services, a double billing of services takes place. The American Hospital Association wishes to make clear that the costs incurred under Part A and Part B relate to different services and therefore there is no double billing. Costs incurred by the hospital for house staff and those who supervise them under Medicare Part A are, and should be, treated and defined as educational costs and not professional costs. If in addition to these services a teaching physician is providing personal and identifiable patient care services, his Part B professional fee is justified in addition to the Part A payments noted above. In the performance of their professional services, residents may be involved, but residents do not bill professional fees to Part B. Failure to reimburse for the different needed services of different individuals would be most destructive to these hospital educational programs.

Because in many situations professional medical services and educational services are simultaneously provided as a joint and inseparable product, a system is needed to identify and record the educational and professional patient care components of such service. In some situations more than one teaching physician could be involved, one taking primary responsibility for the patient—Part B; another taking consultative responsibility—still Part B; and yet another taking primary responsibility for supervision of physician educational activities—Part A. A system is needed that would capture and identify each element so that services appropriately provided will be reimbursed. We would hope a study to develop such a system would be undertaken. We believe its results would ensure full but not excessive payment for teaching physicians' professional fees and educational costs and institutional educational costs.

We support the concept of Recommendation 4 which calls for experimenting with different payment methods. As noted earlier, we support the concept of the unified method of payment for experimentation. The American Hospital Association would be glad to provide our assistance in the design and implementation of such experiments. We would also hope that such programs would be allowed without a rigid and uniform plan of operation. An extremely rigid format or requirement, such as those required under Section 222, of Public Law 92–603, could delay or even deny appropriate experimentation.

As a final point to our comments on teaching physician reimbursement, we would like to support the intent of Recommendation 7. We feel it is important and most realistic to have the Medicaid program, because of its similarity to Medicare in reimbursing inpatient costs, to treat its payment of teaching costs in a manner similar to Medicare's.

CHANGING THE SPECIALTY AND GEOGRAPHIC DISTRIBUTION OF PHYSICIANS

The IOM study recommends that financing mechanisms be changed to provide more equitable support for ambulatory care services so that teaching hospitals and medical schools will have a greater financial capability for meeting the additional costs of training contact physician specialties. The study recommends that the costs of residencies in contact physician specialties should be excluded from provisions of Section 223 of P.L. 92–603 which place a ceiling on the allowable increase in per diem costs under Medicare. The AHA suggests that consideration of modification of limits set under Section 223 should review the merits of excluding not only the costs of residencies in contact specialties but all educational costs, because present requirements adversely impact institutions which are providing educational programs for needed health professionals.

Emergency departments and outpatient departments have increasingly provided the only access for many people to health care when medical services are not otherwise available or easily accessible. Because of the failure of Medicare and Medicaid to pay the full costs for ambulatory care services, often the only potential for some reimbursement for services has been to admit beneficiaries as inpatients when treatment on an outpatient basis would have been appropriate and less costly.

The addition of residencies in ambulatory care settings for better primary care training will add greatly to the costs of such hospital care. Increasingly, other specialties also rotate their residents through ambulatory clinical training—placing a further load on the costs of ambulatory care services. The costs of educating residents and the high level of uncollectible charges and uncovered services in ambulatory clinics under the present system of reimbursement result in a substantial underfunding of hospital ambulatory settings.

Payment by both private third-party payors and the federal government of the financial requirements for providing hospital ambulatory services and the training needed by primary care physicians is absolutely essential if our objective is to increase the numbers of physicians in primary care.

The second IOM recommendation related to physician specialty and geographic distribution calls for support for medical schools and teaching hospitals through special project grants to support ambulatory care residencies. The Association supports this recommendation as a means by which assistance can be given to community hospitals in developing or expanding their residency programs and improving the quality of instruction. However, it should be understood that if changes are not made in reimbursement practices, hospitals will not be in a position to assume full responsibility for all costs when the project grants expire. A long-term solution to the problem is obviously needed.

Recommendation 3 suggests that a combined public and private sector effort be undertaken to monitor and control the number of residency positions by specialty. A commission is proposed to monitor physician specialty distribution and to determine changes in the number of graduate medical education positions in those specialties as a means of increasing specialties that are undersupplied and of achieving an appropriate number in those specialties that seem to be oversupplied. The Commission's responsibility would be to assemble data on specialty distribution, analyze the data, make projections on future supply, and develop a plan for determining the overall numbers needed in various specialties.

The Coordinating Council on Medical Education (CCME) has published a statement urging that 50 percent of all residency positions should be designated for the training of those entering primary care specialties (e.g., pediatrics, obstetrics/gynecology, internal medicine and family practice). Recent statistics from the Office of the National Intern and Resident Matching Program indicate that the private sector has made great strides toward reaching that goal. Fifty-six percent of the first year residency training positions for 1976 were in contact specialties. The issue now is to insure that the increasing number of medical school graduates will have available sufficient primary care residency positions. The CCME and its sponsoring organizations are making a concerted effort to help community hospitals develop or expand existing residency programs in these areas to accommodate more medical school graduates.

Many of the concerns of the Institute of Medicine related to distribution of physicians by specialty have or are being met and have been replaced by other issues. The Association believes that the CCME is dealing effectively with these issues and that at this time a national commission is not needed.

The interim strategy recommendation by the IOM in effect has been met. Over half of the medical students entering residency programs are electing a primary care specialty. The task now is to add additional positions in community hospitals to accommodate their growing numbers.

Care must be exercised that the numbers trained in other specialty areas are not thrown out of balance resulting in poorer quality residency programs or shortages of other specialties in the future. Many specialty societies have made a conscientious study of their output of specialists and have made efforts to balance the numbers with their projected needs. The need for an imposed moratorium would not contribute substantially to those voluntary efforts but instead, might have adverse long-term results.

Additionally, the Liaison Committee on Graduate Medical Education (LCGME) of the CCME has encouraged quality in educational programming through its accreditation efforts. The aim is to increase the number of quality programs, eliminate the poor ones, and help to maintain a balance in specialty output.

As part of its final recommendations on physician distribution, the IOM study group recommended that Medicaid practices which pay physicians at lower levels particularly in underserved areas, be discontinued and a detailed examination of Medicaid administrative practices should be undertaken to document the extent to which these practices affect the availability of physician services in underserved areas. This is further reiteration that the inadequate payments made by Medicaid would seem to discourage physicians from treating Medicaid patients or serving in areas where the predominance of patients are Medicaid-eligible. The Association strongly supports this recommendation and the study suggestion.

FOREIGN MEDICAL GRADUATES

In the recommendations on foreign medical graduates, the IOM study group recommended the elimination of existing incentives for physician immigration, including the removal of medicine as a shortage profession under the Department of Labor's Schedule A for preferred immigration status.

The Coordinating Council on Medical Education has developed an extensive position statement endorsed by all its parent organizations that outlines ways of eliminating existing special provisions for facilitating immigration incentives for physicians and upgrading the quality of the educational programs for existing foreign medical graduates. The federal government was an active participant in those discussions and a national conference was conducted for a wide airing of the recommendations before dissemination.

The AHA believes Congress should actively support those constructive efforts by the CCME in dealing with the problems of limiting as well as assimilating foreign medical graduates.

In conclusion, Mr. Chairman, the American Hospital Association appreciates this opportunity to submit our comments to you and pledges its continued cooperation in solving the problems in determining appropriate methods of payment for services of teaching physicians.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION,
Park Ridge, Ill., September 15, 1976.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, House Committee on Ways and Means, Washington, D.C.

DEAR MR. CHAIRMAN: This letter will relate the views of the American Osteopathic Hospital Association on Medicare policy relating to reimbursement of physicians in teaching hospitals. We would be most appreciative if these comments could be included in the hearing record.

The cost of medical education is rapidly becoming a major issue, and is of increasing importance in the overall problem of rising health care costs.

In March of this year, the Institute of Medicine released its report on Medicare-Medicaid reimbursement policies as they relate to the reimbursement of physicians in teaching hospitals. We agree with one conclusion of the report which said "the analysis indicated that no one payment method would constitute appropriate or equitable compensation in all teaching hospital circumstances, or could be applied universally without adverse effects on graduate medical education in the United States."

Most teaching physicians in osteopathic hospitals volunteer their services. They do not have the intricate contractual arrangements generally associated with teaching physicians in allopathic facilities and institutions. As we move toward these types of contractual arrangements, any payment system which is devised by Medicare or Medicaid should be both simple and recognize the needs of the teaching hospital and the role of the physician teacher.

Since the outset of the Medicare program, reimbursement has been made to hospitals for the program's share of the cost of approved education programs, including internship and residency training programs carried out in the hospitals. Medicare reimbursement to the hospital under Part A is based on costs and includes salaries, fringe benefits and related support costs of house officers and compensation paid to physicians for their teaching and supervisory services. The Medicare dollars to teaching institutions were earmarked as "care" costs, not "teaching" costs.

Payment for physician services to patients has to be on a reasonable charge basis under Part B of the program. The policy adopted by the Social Security Administration was that although reimbursement for all teaching and supervisory functions of a physician, as well as the salaries of interns and residents, was made on a reasonable cost basis to the hospital, the same physician could be paid on a reasonable charge basis if he rendered either "personal and identifiable" services to a patient or was the patient's "attending physiican" and provided "personal and identifiable" direction to the intern and residents who treated his patient.

The IOM study indicates that is a somewhat artificial distinction in the context of graduate medical education since the patient may be cared for by several physicians at various stages of their training, including the attending physician who has formal legal responsibility for his care. The difficulty of making these distinctions has led to Congressional concern about possible abuses of the program. This Association does not condone any such abuses. We share the concern of Congress in regard to this complex matter. We caution, however, that the abuses and actions of a few not be the sole cause to significantly alter a program.

RECOMMENDATIONS

There is great diversity in teaching institutions, physician compensation arrangements, the control of professional fee earnings and expenditures, the organization of patient care, and the involvement in graduate medical education. No one payment method can be applied to a significant proportion of teaching physicians at the present time. Therefore, serious consideration should be given to all forms and methods of payment bearing two important concepts in mind:

First: Whatever system or systems are applied to a given hospital or group of hospitals should be as precise and non-complex as possible. Any such systems should be devised in such a manner as not to add any additional administrative burdens to the institution or further increase their costs.

Second: Whatever system(s) is devised must recognize the needs of both the teaching hospital and the role of the physician teacher. It should meet the hospital's full financial requirements. And should adequately reimburse the teaching physician on a reasonable charge basis for personal and identifiable services to the patient or if he provided personal and identifiable direction to the interns and residents who treated his patient.

Payments for physician services should reflect as closely as possible the full cost of providing the services. In addition, under the cost payment regulations issued under Section 15, Public Law 93–233, inclusion of the payment of the imputed value of volunteer services should be continued. This would allow the osteopathic hospital to improve patient care and to provide some educational and research benefits to its programs.

We agree with the recommendation in the IOM study that institutions should be allowed to shift some costs to an entirely fee-based payment method by notification of the carrier and intermediary that all of their physicians who meet the proper criteria will begin billing on a fee basis for their services at the beginning of the next cost reporting period. At the close of a six-month period, the carrier would conduct an audit of the care provided; if the audit results were deemed satisfactory, and fee billing allowed, the two year phase out of cost reimbursement for supervisory and teaching services would begin with the next accounting period.

The Congress has identified as a priority the need to increase the number of general practitioners in this country. There are presently some 16,000 practicing D.O.'s in the United States, 70 percent of whom are general practitioners and 80–85 percent of whom are involved in the delivery of primary care health services. Osteopathic medical education has identified this need in both its pre- and post-doctoral training programs. Devising an adequate policy for the reimbursement of physicians in osteopathic teaching hospitals will further encourage this trend and result in a further increase in the number of osteopathic general practitioners.

We appreciate the opportunity to present testimony in this vitally important area and I would be pleased to respond to any questions you might have.

Sincerely,

MICHAEL F. DOODY, *President.*

THE ASSOCIATION OF UNIVERSITY RADIOLOGISTS,
Chicago, Ill., September 7, 1976.

Hon. DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health, House Committee on Ways and Means, Washington, D.C.

DEAR MR. ROSTENKOWSKI: The comments below are submitted in response to your request in connection with hearings before your committee later this month to discuss possible legislation dealing with the compensation of teaching physicians under federal programs. They represent the consensus of members of the Society of Chairmen of Academic Radiology Departments, the Society of Chairmen of Academic Radiation Oncology Programs, and the Association of University Radiologists, groups which encompass almost all radiologists practicing in teaching hospitals in this country.

Most of these radiologists are also members of their local and national medical societies and of the American College of Radiology. Through these organizations, they have expressed their opinions on broader issues of physician compensation and upon the problems of academic medicine. We would direct our comments herein to several points which are critical to the academic radiologist in his multi-faceted role.

It has been estimated that about 1,000 radiologists, or some 8 percent of those certified in the United States, could be classified as full-time academic radiologists, holding faculty appointments from a medical school and serving patients in hospitals owned by or affiliated with that school. In addition to this group, an indeterminate number of other radiologists hold clinical or courtesy appointments to teaching programs but are not primarily dependent upon these appointments for their incomes. Thus, in references to academic radiologists, we speak to the full-time group.

The teaching radiologist, like other physicians in an academic setting, normally allocates his time among three types of activities. These are patient care, teaching, and research. While it is difficult to quantify, many academic physicians and particularly senior ones also spend significant amounts of time engaged in administrative and committee responsibilities to their schools, their disciplines and often to the federal government's health planning activities.

With regard to the three principal types of activity, the academic radiologist may well combine two or three in the same basic effort. If, for example, the teaching radiologist performs a fluoroscopic examination with residents or students in attendance, the procedure is likely to take longer than if it were done by a radiologist alone with the patient. This is not to suggest that the patient receives a more complex examination or a greater radiation exposure. Rather, it points up the teacher's explanations of what he is attempting, his reasons and a running discussion of the results. If the findings of the examination are then incorporated into a clinical research project, the triad is completed in a single patient-oriented procedure. While there are few if any patient procedures in a teaching department which do not benefit students as well as patients, there are in most such departments some significant amounts of physician time spent upon teaching and research activities which do not benefit individual patents.

It is fair to observe that most teaching hospitals are to some extent referral centers which attract complex and difficult patient problems. Thus, the range and volume of radiology procedures tend to be more sophisticated and substantial than would be found in most community hospitals. Again, this does not suggest that unneeded or unnecessarily complex examinations are scheduled for teaching or research ends. Rather, it indicates that in a well-balanced institution, these objectives reinforce each other to the benefit of all concerned from the individual patient to the academician, to his students, and to the community which supports the whole.

To our knowledge, no precise figures exist on the types of arrangements currently enjoyed by academic radiologists and their institutions. Several generalizations may be pertinent. One such generalization is that with few exceptions, the incomes of academic radiologists, like those of their academic colleagues, tend to be lower than the incomes of private radiologists and other physicians in the same communities.

This is true even though the patient services of academic radiologists are normally charged to patients or third parties at prevailing rates. The difference is that the academic radiologists spend less than full-time on patient care services and their other activities are normally compensated through their schools or hospitals or outside funding sources at a rate less than what could be produced by patient care activities. In many situations, the acceptance of ceilings upon incomes under faculty agreements and the diversion of income from the radiology department to other institutional objectives have also resulted in a lower level of physician income than would have resulted from the volume of service provided independently of the academic setting.

One other bit of explanation may be helpful. More than two-thirds of radiologists in voluntary hospitals—including teaching hospitals—now practice on a basis which is financially independent from the hospital. Thus, the billing to patients reflects two components for radiology. One is the institutional component to cover the use of the departmental facilities, technical personnel and a justifiable overhead factor. The other is a professional component which reflects the physician's direct time involvement with the patient. This involvement would cover time spent reviewing films and other images and consulting with other physicians about the radiologic findings, as well as the time actually spent with the patient in obtaining the visual information from which a diagnosis may be formed. On the radiation therapy side, it would involve treatment planning as well as patient visits and supervision of daily treatments.

It is our impression that a majority of academic radiologists now have agreements with their schools and hospitals which allow them to bill patients for services and to retain the results as physician income. In some academic institutions, such physician income is supplemented by salaries from the school or hospital to cover the teaching and research activities not related to patient care. In others, the institutional stipend may be token or even represent a negative income resulting from a levy against professional earnings above a fixed ceiling or as a percentage of collections.

Some independent academic practice situations are functioning to the satisfaction of all concerned even when a substantial portion of patients are covered by Medicaid or other public programs which are slow and inadequate in paying for services to their beneficiaries. The only difference between the problems of the academic radiologist and those of his colleagues in other practices is that the academic radiologist has less liberty to select his patient than do some other groups of physicians.

All of this is to suggest strongly that the academic radiologist is functioning within the current compensation patterns in a manner which does not impose undue strains or expenses upon the systems and which neither over nor under compensates him relative to his peers in the academic community.

Thus, most academic radiologists would oppose compensation arrangements such as those proposed in section 227 of Public Law 92–603. Any such proposals would have the effect of making substantial changes in existing methods. They would severely disadvantage academic departments and make all the more difficult the decision by radiologists to elect an academic milieu at some financial sacrifice to themselves and their families.

This would come at a time when other changes in patterns of medical care for Americans mandated by renewed emphasis upon primary care seem likely to add to the obligations of specialists in radiology to provide the consultative diagnostic services and highly sophisticated cancer treatment programs which will be required by increasing numbers of Americans.

Projections from studies within radiology would suggest that the current levels of manpower in the specialty should prove adequate for diagnostic burdens. However, there remains an estimated shortage of therapeutic radiologists which could result in less than adequate staffing of cancer treatment centers across the country. Further, the imposition of professional and public requirements for continuing professional education are adding to the burdens upon academic radiology. Thus, in our estimation, it will be essential that the critical mass of academic radiology and the bases of its support not be diminished by needed actions to control health care costs.

These comments have necessarily been general in nature and are intended to add to the committee's understanding of our situation. Since its exploration of these problems will obviously continue during coming months, we would welcome further opportunities to comment upon specific legislative proposals. We request that this letter be made a part of your current hearing record.

Sincerely,

ROBERT D. MOSELEY, Jr., M.D.,
Conjoint Committee on Government Affairs, Society of Chairmen of Academic Radiology Departments-Association of University Radiologists.

STATEMENT OF THE BLUE CROSS ASSOCIATION, NEIL HOLLANDER, VICE PRESIDENT, HEALTH CARE SERVICES

This statement is submitted by the Blue Cross Association for the record of the Ways and Means Health Subcommittee's September 16, 1976 hearing on reimbursement of physicians in teaching hospitals. The comments are presented in summary form. We would be pleased to provide more detailed comments at the request of the Committee.

The Blue Cross Organization has considerable experience with the problems and issues surrounding payment for provider based physicians generally and teaching physicians specifically.

Our experience, and a review of the legislative history leads us to conclude that program implementation has departed significantly from the original intent of Congress—that is, where the physician is compensated by the hospital, payment for the physician's services would be made through the hospital insurance trust fund (Part A). All other physicians would be reimbursed through the supplementary medical insurance trust fund (Part B). We believe that intent was sound. Therefore, it is our recommendation (presented in detail later) that total medicare payment to physicians who do no have a private patient relationship should be made from one fund, either Part A or Part B. The physician reimbursement from the Part A or Part B fund should be dependent upon the nature of the contractual arrangement between the hospital and the physician. This recommendation would simplify program administration, minimize the potential for program abuse and provide a basis for review of the reasonableness of physician compensation. Furthermore, it recognizes that, because of the complex nature of reimbursing for physicians' services, program changes will need to be incremental in order to avoid complete disruption of the system that has evolved since the inception of Medicare and which, to a great extent, is still appropriate.

In developing our recommendations, we found that the recent study published by the Institute of Medicine of the National Academy of Sciences (IOM/NAS) provided many important insights and guidelines for reimbursement of physicians in teaching settings. The IOM/NAS study promulgated a series of principles against which any physician reimbursement mechanism should be evaluated. We support those principles.

The IOM/NAS study recommends that the cost basis of reimbursement method under Public Law 92–603 with modifications, or the fee basis of reimbursement under Public Law 92–603, and their own "unified payment" method be available for physicians on an institution-wide basis. Each of the recommendations, however, falls short of meeting all of the design principles proposed by the IOM. Application of the IOM recommendation would require all physicians in an institution to adopt the same reimbursement method. We question the need for such a requirement. We believe the physician/hospital right to enter into a contractual arrangement must continue to be recognized. The controlling factor in determining the basis of reimbursement should not be the contractual agreement between the physician and the hospital. The focus of the reimbursement method must be on the result (i.e., amount paid under the contract) not on the form of the transaction.

The IOM/NAS study proposes the continued availability of the cost method of reimbursement, with certain modifications, on an institution-wide basis. We generally support that proposal subject to the following modifications:

(1) The election of the cost method should be available to any physician within the institution rather than requiring all physicians in that institution to make the election. Physicians' services to institutional patients (patients for which a private patient relationship does not exist) must be reimbursed on a cost basis.

(2) Where the cost method applies, the cost of physician services, other than volunteer services, rendered by physicians on the hospital and/or medical school staff, should be treated on an actual cost basis as any other allowable hospital cost, subject to the usual cost finding and cost apportionment techniques.

(3) The imputed cost of physicians who volunteer their services should continue to be calculated on a per diem basis and settled as a separate computation through the cost report.

(4) Billing for physician services under the cost method should utilize the hospital's established schedule of charges for those services. This would eliminate the currently proposed requirement to bill a per diem charge for physician services rendered to Medicare beneficiaries. Further, it would not require any revision to either the existing claims processing mechanism or the cost reporting format. Payment to all provider-based physicians who do not have a "Private Patient Relationship", should be based on the combined billing principle and would be made by the Part A intermediary, this provision would apply most frequently to radiologists, pathologists, cardiologists and emergency room physicians. Splits between the Part A and Part B trust funds could be made at the end of the year based on the provider cost report.

In connection with the cost reimbursement approach, IOM/NAS recommended a separate fee reimbursement mechanism for physician services rendered in special care units. We believe this would be unnecessary under the proposal outlined above.

The IOM/NAS study recommends the availability of a fee for service method of reimbursement as the sole payment method for all physicians in a teaching institution. We disagree with that proposal. While we recognize that such a change would result in payment for physician services from only one trust fund, it would necessitate significant changes in existing physician arrangements and focuses on the process (i.e., fee for service) rather than reasonableness of the result (i.e., amount paid). Furthermore, we believe such a change would contribute to an increase in health care costs both for patients and the Medicare Program.

We recommend that the fee method of reimbursement be available only for physicians who have a "Private Patient Relationship" with patients to whom they render services. These physicians may also be compensated by the provider for other services, including supervisory services. In these circumstances, the following would apply:

(I) The physician would be precluded from billing for any patient care services except those rendered to that physician's private patients, and

(II) The hospital and physician would be required to certify that the billing was for services rendered to that physician's private patients. Therefore, the determination of the private patient status would be made jointly by the hospital and the physician.

The IOM/NAS study proposed a "Unified Payment Method" which would require that a separate physician organization receive all the compensation for the teaching physicians and certain house officers on a fee basis. This method represents a significant departure from the present organizational structure for training physicians in the hospital setting. Without testing and evaluation, we cannot comment on its appropriateness for physician training. However, we are concerned that this method may result in increased cost for physician services and training both to the patient and the Medicare program. We agree with the IOM/NAS committee recommendation that experimentation should be conducted as to the impact of the "unified" and "lump sum" payment methods. The concept of negotiated rate under the "lump sum" payment has elements of prospectivity which should be considered with prospective payment experiments for other hospital costs.

The entire issue of the "reasonableness" of physicians compensation was not addressed by the IOM/NAS study. Furthermore, "reasonable" physician compensation guidelines have not been promulgated by the Medicare program. We have made specific proposals in connection with the Senate Bill No. 3205 introduced by Senator Talmadge. These proposals provided that payments by providers to physicians should be reviewed for reasonableness. These reviews should:

Focus on the total amount paid to the physicians rather than on the type of arrangement, and

Establish an acceptable level and rate of increase of payment, published in advance for various categories of provider-based physicians. The guidelines would be based on current experience in comparable settings.

We appreciate the opportunity to submit our comments on this topic.

STATEMENT OF THE ILLINOIS MASONIC MEDICAL CENTER, CHICAGO, ILL., THOMAS H. AINSWORTH, JR., M.D.

Mr. Chairman, I am Thomas H. Ainsworth, Jr., M.D., Medical Director and Director of Hospital Education Programs of the Illinois Masonic Medical Center in Chicago, Illinois. The following testimony represents a consensus of the teaching physicians actively involved in undergraduate, graduate, and continuing medical education at IMMC.

Our institution is a 566-bed non-profit voluntary hospital affiliated with the University of Illinois Abraham Lincoln School of Medicine. As one of ten affiliated hospitals of the University of Illinois, we share responsibility for approximately 40 percent of the undergraduate medical education curriculum; we have 107 house staff actively involved in graduate medical education programs approved by the Liaison Committee on Graduate Medical Education and by the University of Illinois; and are actively involved in continuing medical education. We are a member institution of the Council of Teaching Hospitals of the Association of American Medical Colleges. We believe that our institution is representative of the urban community teaching hospitals affiliated with academic medical centers, which not only have a major share in medical education, but also provide the highest percentage of health care under the federal programs of Medicare and Medicaid; approximately 60 percent of our patient days are covered by government programs, Title XVIII, XIX, and V.

We have studied the findings and recommendations of the study of Medicare-Medicaid reimbursement in the teaching setting that was conducted at the request of Congress by the Institute of Medicine of the National Academy of Sciences. We wish to express grave concern over the possible implementation of some of their recommendations. We wish to comment on the potential effect on the educational programs conducted at our institution relating to the recommendations suggested in the section of the report addressing "payment for teaching physicians' services in teaching hospitals." Our testimony will be limited to comment on this section of the report.

It is necessary to review the milieu in which graduate medical education is provided in the United States. To this point, there has been a general consensus shared by the public, third party payers, and government programs that the cost of graduate medical education in the United States will be financed by patient care revenues. Graduate medical education is provided in the hospital setting. While it is true that 90 percent of all graduate medical education is now university affiliated and the majority of residency positions are found in the academic medical center hospital, the majority of graduate medical education programs are currently located in affiliated community teaching hospitals. For example, the graduate educational programs of the Abraham Lincoln School of Medicine are also provided in 10 affiliated hospitals, all about the same size as the University Hospital. This is particularly true of graduate medical education programs in primary care, where the majority of these programs and positions are located in the affiliated hospitals.

The Institute of Medicine's study recommends three options be made available to the hospital for payment for teaching physicians' services. In general we feel that the implementation of recommendations 1, 2, or 3 would provide an "overkill" solution to the problem which led to the Institute of Medicine's study. It is our understanding that section 227 of Public Law 92–603 was designed to prevent the possibility of "double billing" for patient care rendered in the teaching setting; that is, that the activities of the resident house officers are cost reimbursed under Medicare Part A, and the medical care services of the teaching physician under Medicare Part B could be construed as "double billing." It should be pointed out that the financing of house officers is covered in Chapter IV of the Medicare Provider Reimbursement Manual entitled, "Cost of Educational Activities." While it is true that in some teaching institutions, particularly in public general hospitals, house officers provide a majority of patient care services with a minimum involvement of the supervising teaching physicians, this is not the case in most non-profit voluntary community teaching hospitals. In institutions such as ours, the involvement of the resident in the service is necessary to provide for the education of future physicians; he will provide certain patient care services to many patients, private-pay, patients covered by other third party payers, as well as Medicare patients. These services should be viewed as an educational cost. If the teaching physician meets all the requirements of providing personal identifiable patient services, a Part B fee is certainly justified. The house officer also provides for 24-hours-a-day, 7-days-a-week access of hospitalized patients to services of a physician, which is an institutional provided responsibility. To maintain high standards of quality and safety, institutions not involved in teaching programs would have to employ other physicians to provide this service. This should also be considered a necessary reimbursable cost of the institutional provider.

We most strongly oppose the Institute of Medicine's recommendation that "all teaching physicians rendering service in a hospital would be covered by a single payment method; mixed and geographic settings for different payment within a hospital would not be recognized." This recommendation does not recognize the variation in organization of teaching programs in the different specialties within the same hospital. For a community teaching hospital, such a requirement completely negates their recommendation that institutions should be free to shift from any one of their three recommended payment methods to another. While such a recommendation might be feasible in an academic medical center university hospital or even in a public general hospital, it is not possible in the voluntary non-profit community teaching hospital where the majority of primary care graduate medical education programs are conducted. Hospitals such as ours rely heavily upon the voluntary non-salaried teaching physician who is engaged in private practice. To opt for their recommendation 1, a cost-based method of payment, would totally eliminate voluntary teaching physicians from our educational programs. While the Institute of Medicine's recommendation 2, a unified method of payment could be adapted to our family practice residency program, it would not be applicable to any other department. It would be impossible to move our entire staff to the HMO type of organizational configuration required by this recommendation.

We are particularly concerned with the Institute of Medicine's recommendation 3, a free-based method of payment. We do agree with the Institute of Medicine's recommendation that the requirement of a preadmission relationship between the physician and patient, as originally required under section 227 of Public Law 92–603, must be removed as a requirement for reimbursement. However, we are especially concerned with the recommendation that no cost reimbursement should be allowed for:

> Supervision or teaching of house officers, except the director of medical education as noted below;
>
> Regular or routine teaching physician service on general care nursing units; and
>
> Administrative services of teaching physicians, except where there is a written agreement defining the specific services to be performed; for example, director of medical education, administration of a pulmonary function laboratory, cardiac catherization laboratory, or the like.

Our comments here are very similar to the comments prepared by the Association of American Medical Colleges, which we endorse. We wish to emphasize their comment that, "It should be made clear that the current patterns of graduate medical education include time spent by teaching physicians with patients who are not their patients." For example, in a recent on-site accreditation review by the residency review committee in internal medicine, we were required to add such teaching physicians to provide teaching rounds on nursing units three days per week. To be accredited, therefore, this activity is a requirement for an approved program; and such educational costs should be reimbursable to the hospital as an educational institution. This is totally separate from patient care services. To eliminate such cost reimbursement under a fee-based method of payment would require that not only patient care services but also educational services must all be covered by the fee-for-service reimbursement. We wish to point out that this same amount of reimbursement would be paid to a non-teaching physician providing non-teaching patient care services only. This would mean that Medicare-Medicaid would not be meeting their fair share of the costs of graduate medical education.

Should the recommendations of the Institute of Medicine be implemented in our institution, it would have one of two effects: we would have to shift the burden of payment for graduate medical education to the private-paying patient or eliminate our educational programs. This is particularly true of Illinois Masonic Medical Center, which is 60 percent cost reimbursed by these federal programs. It would appear only equitable that until other mechanisms are developed for payment of graduate medical education, all third party purchasers of care, including Medicare and Medicaid, should equally share in the cost of the graduate medical educational programs.

This brings us to a major criticism of the recommendations of the Steering Committee of the Institute of Medicine's study. We heartily endorse the principles applicable to the teaching physician, the beneficiary, the health insurance program, and general principles found on pages 213, 214, and 215 of the report (which are attached as an appendix to this testimony for easy reference); but we are very concerned with their evaluation of the payment methods they recommend against these principles. The Steering Committee's recommendations appear to be applicable to the academic medical center teaching hospital, but are certainly not applicable to the voluntary non-profit affiliated teaching hospital which, we have mentioned before, is the site of a majority of primary care graduate medical education programs. Teaching hospitals such as ours have a stated policy that all patients admitted to the institution by their private physicians are also "teaching patients." To require segregation of teaching patients from other patients in our institution would lead to a two-class system of health care, place an increasing burden upon the private patient, or, more likely, make us abandon our educational programs.

We would recommend, therefore, that their recommendations for the three options for which teaching physicians can be reimbursed, cost-based, unified, and fee-based method, be altered according to the recommendations made by the Association of American Medical Colleges; and, furthermore, that choice of one of these three options be permitted by various programs within the institution. We would agree that individual physicians within the teaching institution should not have this choice, but the various cost centers required for Medicare accounting should have the freedom of any one of the three options within the same institution.

In summary, we would like to state that the implementation of the recommendations contained in the Institute of Medicine's study would have serious consequences on the teaching programs, particularly in primary care, which are based in the community teaching hospital. The fee-based mechanism of payment appears to be the only viable option in such a setting. Until other mechanisms are developed to pay for graduate medical education in the United States, simultaneous cost reimbursement, not only for house staff salaries, but also for supervision and administrative services of teaching physicians for their educational activity should be permitted. I.L. 372 guidelines should be continued to eliminate any suspicion or chance of "double billing" for the same services.

Appendix

REIMBURSEMENT PRINCIPLES IDENTIFIED BY THE INSTITUTE OF MEDICINE STUDY

Since the principles represent such diverse and sometimes conflicting interests, no payment method can fully satisfy all of them and, ultimately, there must be trade-offs and compromises based on value judgments.

Principles Applicable to the Teaching Physician

Principle P1. Government payment methods should be appropriate for the way in which care is delivered.—If teaching physicians provide care in a manner similar to non-teaching physicians, the payment for their patient care services should be similar. Modifications in the payment methods should be made that are appropriate to other modes of delivering medical care in teaching settings; for example, the physician team approach.

Principle P2. Government payment methods should be neutral whether teaching physicians are self-employed or are employed by a medical school, hospital, or other organization.—The amount of payment for patient care services should be determined without regard to the employment status of the teaching physician.

Principle P3. Government payment methods should be neutral with regard to the use of patient care revenues by teaching physicians.—The government programs should pay fairly and equitably for the services rendered, and having made such payment, their interest in the use of the payment should cease.

Principles Applicable to the Beneficiary

Principle B1. Government payment methods for patient care services of teaching physicians should not create or maintain classes of patients based on the sources of payment for the services.—Methods of payment should not aggravate differences in care by providing incentives for creating or maintaining private and non-private hospital settings to which patients are assigned on the basis of non-medical criteria.

Principle B2. Government payment methods for patient care services of teaching physicians should not discourage physician and institutional provider participation in the programs.—Any changes in the payment method should not discourage teaching physicians from maintaining or increasing the number of patients in teaching settings or from maintaining or increasing their commitment to teaching and patient care activities.

Principles Applicable to the Health Insurance Program

Principle M1. Government payment methods should result in reasonable program costs in relation to the services provided.—The government should be a prudent buyer of physician services for program beneficiaries, regardless of whether payment is made on the basis of reasonable costs or reasonable charges.

Principle M2. Government payment methods should influence professional judgments toward the provision of medically necessary services in settings appropriate to the medical need of the beneficiary.—Payment methods should not influence the physician to treat the beneficiary in an inpatient setting when treatment in an outpatient setting is appropriate to the beneficiary's medical need, and vice versa.

Principle M3. Government payment methods should not influence the physician or the beneficiary to select one medically appropriate setting over another.—Given a choice of appropriate settings for the provision of medically necessary services, the payment method should not influence the physician or the beneficiary to select one hospital over another or one outpatient setting over another.

General Principles

Principle G1. Government payment methods should allow for experimentation and change.—Government programs should be allowed to conduct limited experiments with payment methods that offer the possibility of better service to beneficiaries, reduced cost of services, or reduced administrative cost. Government payment methods should not lock graduate medical education and medical care delivery into a mold that is right for a particular time period or for a particular set of institutions.

Principle G2. Government payment methods should be fair and comprehensible to the beneficiary, the physician, the institutional provider, and the program.—The payment method should encourage the use of medically necessary services by beneficiaries, encourage physicians and institutional providers to proivde medically necessary services to beneficiaries, and assist the program to pay equitably and fairly for medically necessary services to its beneficiaries without excessive administrative costs.

[The following letter is in response to a request made by the subcommittee at p. 360.]

American Medical Association,
Chicago, Ill., December 15, 1976.

Hon. Dan Rostenkowski,
Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Dear Mr. Rostenkowski: This is in response to a request made by your Subcommittee during testimony presented by the American Medical Association, September 15, 1976, at hearings held by your Subcommittee on the general subject of revisions in physician reimbursement under Medicare and on H.R. 13080, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

At the close of the formal testimony, the witnesses were asked for the Association's views on H.R. 15152, which would recognize payment under Part B of Medicare for services furnished by physician extenders. It was indicated by the witnesses at that time that the legislation had not been reviewed by the Association but that it was scheduled for early consideration.

This legislation has now received careful study. We support its objectives but believe that it should not be enacted as presently written since it incorporates certain undesirable aspects. We believe that certain amendments should be made believe in the legislation before it is acted upon.

Services of physician extenders to be recognized for reimbursement under Part B of Medicare should include services performed regardless of whether the physician was actually present and regardless of whether the services were performed in the physician's office or at some other site. However, services of such extenders should be recognized only if they are performed in conformance with the laws and regulations of the State in which the service occurs, only if the extender performs services under the supervision of a physician, and only if the services are billed by and in the name of the supervising physician. We believe that recognition for payment under these principles would be in keeping with the profession's expanding use of physician extenders under appropriate circumstances while recognizing that physician extenders are not, nor should they be, independent practitioners.

Concerning H.R. 15152, as proposed, there are several objectionable provisions, which provisions do not, in our opinion, follow the principles stated above.

The bill defines a physician extender as one "who has successfully completed a program of study approved by the Secretary" of HEW, *or* as one "who is holding a valid certificate as a physician assistant issued by the National Commission on Certification of Physician's Assistants or by any qualified successor to the Commission", or as one who is "licensed or otherwise recognized by a State as qualified to provide primary health care services in the State in which such services are rendered." We believe that this definition in allowing the alternative methods for qualifying for reimbursement in the bill is objectionable in that it provides for direct approval of training programs by the Secretary, fails to recognize other appropriate accrediting agencies, and supersedes state licensing prerogatives.

As to the provision for training program approval by the Secretary, we believe this alternative should not be supported. The Secretary does not now "approve" programs, and it is both inappropriate and unwarranted to extend this authority to him. While the Secretary may recognize an accediting body, the accreditation of a training program should not be placed within the direct authority of the Secretary.

Furthermore, we believe that recognition should be given to existing arcreditation bodies for purposes of training programs. Such recognition would be accomplished in the bill by language which would give recognition to an individual who "has completed successfully an educational program for physician's assistants accredited by the American Medical Association or other recognized accrediting agency or has been certified by the National Commission on Certification of Physician's Assistants".

Nevertheless, even inclusion of more appropriate language as to accreditation of training programs should not be an alternative to meeting state requirements.

As presently written, H.R. 15152 would authorize reimbursement for services of a physician extender under Medicare even if the State in which the person performed services did not recognize the extender. We believe that this is highly objectionable. Recognition of a physician extender should not be outside of state requirements.

We also believe that, unless stated clearly to the contrary, the proposed revision to Part B of Medicare contemplated by H.R. 15152 would be interpreted by some as justifying direct reimbursement to a physician extender. The legislative language should therefore clearly provide that reimbursement of services performed by such extenders is to be made only upon a bill for such services submitted by and in the name of the supervising physician.

In conclusion we would reiterate the principles which we believe are essential in recognizing Medicare reimbursement of physician extenders: recognition of services only if performed in conformance with the laws of the State, recognition of the extender only if performing services while under the supervision of a physician (whether performed in his presence or at a remote site), and reimbursement for services only if the services are billed by and in the name of the supervising physician.

We are hopeful that our comments will be helpful to you, and we appreciate the opportunity to offer our views on this legislation.

Sincerely,

James H. Sammons, M.D.,
Executive Vice President.

○

7808LE PA 206 Group
11-14-12 16207 XL

CMS LIBRARY
3 8095 00016655 9